USAID/TANZANIA

REPRODUCTIVE HEALTH, CHILD SURVIVAL AND INFECTIOUS DISEASES

STRATEGY RECOMMENDATIONS FOR 2005-2014

FINAL VERSION, 1 October 2003

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SO1 - Increased use of family planning/maternal and child health and HIV/AIDS preventive measures

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EXECUTIVE SUMMARY

USAID/Tanzania is designing a new ten year (2005-2014) mission strategy. This report provides consultant recommendations for the reproductive health, child survival and infectious disease (non-HIV/AIDS) components of the new strategy. The context for this strategy is challenging: stagnating and sometimes declining indicators for child survival, maternal health and reproductive health, in the midst of a growing HIV/AIDS epidemic.

The Government of Tanzania, with significant donor assistance, has since independence developed an extensive health infrastructure which, when combined with a substantial rural presence of Faith-based organizations, has the capacity to serve most of its modest, (35 million), but dispersed population. The Ministry of Health embarked on a Health Sector Reform (HSR) program in the mid 1990s that has now moved into its second phase with most health planning, management and service responsibilities decentralized and passed to newly established district health teams. Most donor assistance is provided via an elaborate SWAp (sector-wide assistance program) mechanism that operates through grants provided to MOH units via a "central Basket" and provided to districts via a "District Basket". USAID has correctly supported the HSR effort and the SWAp, but does not contribute financially to the SWAp. USAID funds are programmed "outside the Baskets".

USAID historically has been the lead donor in family planning (along with UNFPA) and was the first and still is the largest bilateral donor for HIV/AIDS. USAID contributions to child survival and infectious diseases have been considerably smaller, but have been made very positive contributions. Under the present health strategy (1998-2003), USAID assistance interventions have gradually expanded and become more diverse. These programs are now implemented by 19 separate cooperating agencies (CAs), most with no permanent presence in Tanzania. The inefficiencies of this assistance modality are clearly recognized by the MOH, USAID and the CAs.

No evaluation of the present program has been carried out; therefore this strategy team found it difficult to describe the strengths and weaknesses of the present program with quantitative accuracy. Also, no DHS data is available since early in the strategy period (1998). Information was gathered over 3 weeks through interviews with MOH, CAs, donor representatives and USAID's strong mission staff, along with field trips and a careful review of available documentation. This provided evidence of a USAID program with many successes, despite the difficulties of the program modality, major mid-strategy changes in the family planning program due to Mexico City restrictions, and gradually decreasing funding for all programs except HIV/AIDS (which is rapidly expanding).

Funding parameters for the new 2004-2114 strategy are essentially straight-line projections of present funding levels - with a total of $7 million/year available for non-HIV/AIDS activities, a relatively low per capita assistance level. USAID's comparative advantages are recognized and appreciated in Tanzania and the MOH, and non-government organizations (especially FBOs), are requesting significant future USAID

support. The MOH also appears ready to accept a traditional bilateral USAID program modality with more in-country CA presence.

The USAID mission goal for the 2005-2114 strategy is "to accelerate Tanzania's progress toward sustainable development and reduced poverty and….to improve the quality of life in Tanzania". USAID's draft health program goal is "halting the deterioration in health status in Tanzania". This report's recommended program vision is to build on Tanzania's strengths (its physical infrastructure, large and consistent multi-donor presence, the continuing health sector reform process) to bring about "people-level improvements in RCH and ID health status". Four key elements of this vision are:

- Support for efficient district and community-level application of health reform
- Encourage public-voluntary partnerships and an efficient mix of public, voluntary and private sector provider services
- Foster quality in the provision of state-of-the-art RCH and ID services
- Stimulate critical citizenry, including the demand for quality RCH and ID services

The proposed strategy anticipates synergy and close coordination with the mission's new HIV-AIDS strategy (which has not yet been designed, but is likely to build on the present HIV/AIDS program). It also recommends closer linkages with the mission's DG and Natural Resource Management SOs, as well as the proposed Program Support Objective.

To elaborate the proposed strategy, a draft SO Framework along with illustrative program outcomes, are provided in the text of this report. The strategy is divided into National scope activities and Geographic-specific activities with the balance shifting towards the latter in consonance with this stage of Tanzania's health sector reform process. Key changes from the present strategy are:

Public Sector:

- Greater technical and financial support for Zonal Training Centers to support district-level decentralization (innovative training for planning/managment, follow-up supervision and in-service technical training)
- Gradually reduced financial support for RCHS (to be replaced by Basket funding)
- Emphasis on the timely availability and use of quality data for decision making by the MOH and by district health teams (a Data for Decision-Making component).
- Development of effective Logistics Management and ID Surveillance systems
- Support for the QIRI (quality improvement) pilot completed as soon as feasible. Provide very limited future support to an expected nationwide facility-wide QA framework, with USAID TA input focused, at most, on the Recognition and/or Community involvement components.
- Consider support for pre-service curricula changes to ensure SOTA RCH and ID knowledge in newly trained providers
- Encourage a "results" orientation via guidelines for Basket funding and pilot incentive schemes

Voluntary Sector:

- Establish a new "Strengthened Health Service Partners" grant program available to FBOs and other umbrella (e.g. women, youth) organizations ($75-200,000 per grant)
- Revisit the Voluntary Sector Health Program (VSHP). Reduce FP and CS funding for VSHP and target it very carefully, tracking numerical targets such as CYP and immunization coverage.
- Expand and improve the social marketing program
- Encourage community mobilization and CBD programs via both the voluntary and public sectors
- Strengthen FBO/NGO advocacy skills & media reporting skills on health issues

Other Activities:

- Policy activities carried out as cross-cutting issues; rather than a separate IR. Focus is on dissemination and application of existing policies.
- BCC is also cross-cutting, based on a clear "inverted" BCC strategy
- New Fostering Leadership program to encourage FP and CS champions
- More inter-sectoral activities with USAID DG and ENV programs

Major Changes in Technical Focus:

- New program emphasis on chronic malnutrition
- Revitalized Long-term and Permanent Method program (via both public and voluntary sectors)
- Revitalized CBD program
- Integration of Maternal health, child survival and HIV-AIDS program activities

The report's final section describes a series of design assumptions and design issues that need further review and analysis before the new strategy should be completed.

1. BACKGROUND AND METHODOLOGY

USAID/Tanzania has directly supported implementation of RH, CS and ID programs in Tanzania since the late 1970s. In 1990 the Mission approved the Family Planning Services Support Project with the following objectives:

(a) To increase contraceptive acceptance and use;
(b) To improve the health and well being of women and children through spacing births by at least two years apart in every family; and
(c) To make family planning services available to all who need it as well as directing family life education program and family planning services towards men as well as women.

In 1997-1998 as the government focused on decentralization and health care reform, the Mission enlarged its approach to focus on quality of care, integrate family planning into reproductive health and child survival, including support for immunization and vitamin A, and develop a sector wide approach. HIV/AIDS activities also increased, gradually at first, then very rapidly.

USAID earmarks for health and HIV/AIDS in FY 2002 included 24% of the $16,700,000 budget for population, 14% for child survival, 11% for infectious diseases, and 51% for HIV/AIDS. The total budget for FY 2003 increased to US$ 22.5 million of which $ 15 million is provided for HIV/AIDS programs. The overall budget for FY 2005 will increase to over US$ 25 million of which population will receive $4 million, child survival $1.8 million, and infectious diseases $1.2 million. A new HIV strategy will be designed as a new HIV Strategic Objective to respond to this increase in funding. The Presidential Initiative on prevention of mother to child transmission (PMTCT) will add $5.45 million to support for HIV/AIDS activities, so the Mission will manage $25.05 million in the health sector with approximately 77-80% for HIV/AIDS.

At the USAID/Tanzania annual health program planning meeting in Feb 2003 alarming statistics about slowing progress in achievement of key indicators in reproductive health and child survival, including increased maternal and infant mortality and decreased numbers of attended births were presented. This apparent slow-down in Tanzania is consistent with child survival and family planning trends from other parts of the developing world. It has encouraged the Mission to think about how it can best reposition RH, CS and ID activities in spite of decreasing resources going to these programs and in the presence of a dramatically expanding HIV/AIDS program.

Therefore a four-person consultant team was commissioned to "conduct a review of RH, CS and ID strategies and activities including those implemented with USAID funds in Tanzania and to identify key methodologies and approaches which should form part of a new USAID/Tanzania strategy, to be designed concurrently with the new country strategy (2005-2015)."

This team worked together in Tanzania from June 30 to July 18, 2003. The team gathered information by reviewing USAID and CA program documentation for the past strategy period (1999-2004), and by conducting interviews with Government of Tanzania officials, CA staff, USAID mission personnel, including during 4-day field trips to Arusha and Iringa regions. The team presented its recommendations to the USAID mission on July 17 and submitted a draft report to USAID/Tanzania on July 30. After receiving and incorporating changes related to mission comments, the final report was transmitted to USAID/Tanzania on August 15 for use as an internal USAID planning document. Two members of the consultant team and the USAID/Tanzania Health Officer presented the major recommendations at a USAID/Washington meeting on August 21 and benefited from suggestions provided by senior USAID/Washington health officers.

2. SUMMARY HEALTH PROFILE OF TANZANIA

The population of Tanzania Mainland has grown from 12,313,000 in the first Post Independence census in 1967 to 33,584, 000 according to the census held in August 2002. The annual population growth rate during the 1988-2002 period was 2.9%. Infants and under-five children constitutes about 5% and 20% of the total population respectively. The average household size has decreased from 5.2 in 1988 to 4.9 in 2002. Unless the current rate of HIV/AIDS spread is reduced, the dependency ratio and the demographic profiles will likely change significantly in the near future. The 1999 TDHS report shows that the contraceptive prevalence rate for all methods has doubled since 1991-92, from 10 to 22% for all women. However, the CPR for effective modern contraceptives is only 16% for all women. The TFR is still high at 5.6. The population is still very youthful with about 60% of Tanzanians aged less than 25 years.

Tanzania has a fairly well distributed health care system. About 80% of the population has access to health services and about 90% of the population lives within 10 km of a health care facility. According to the Ministry of Health annual reports (2001), there are registered 4,844 health care facilities of which 2,877 (59.4%) are government, 848 (17.5%) are voluntary (Faith Based Organizations), 283 (5.6%) are parastatal and 836 (12.3%) are private. The parastatal and private facilities are mostly urban based and the FBOs are believed to provide health care services to between 40-45% of all Tanzanians and especially more so in rural areas. Although significant efforts have been made to establish standards of care, improve the supply of drugs and the training of staff, the quality of health services delivery is still believed to be low.

The 2nd Health Sector Strategic Plan (HSSP), 2003-2006 indicates that the majority of skilled health workers work in the large towns leaving facilities in rural areas understaffed. The ratio per 100,000 populations to nurse and physician is 38.9 and 2.5 respectively, quite low even by African standards. Nearly 35% of the health workers are employed in the private sector of which 40% work in the for-profit private sector. About 31% of the existing 54,200 workers in the health sector are unskilled. Staff emoluments take up about 80% of the government financial allocation to health expenditure. Between 1999-2002 there have been some notable improvements in budget allocation to the health sector. However, it

should be noted that the share of the health sector budget is still low for such a priority sector and for FY 2002/2003 this was only 8.7% of the total. The 2001 Abuja summit of African heads of state set the target of 15% of government budgets to be spent on health. It is to be noted that in the last 5 years dependency on donor funds to finance health has increased considerably as the GOT budget and personnel ceilings have been tightened as part of a structural adjustment program. Donor funds, e.g. the Basket funds, have supplemented, and possibly replaced, some of the government's budget allocations for health in recent years.

Life expectancy has declined considerably in the country due to rising mortality rates. Communicable diseases are the main cause of morbidity and mortality. Health facility based data as compiled in the Health Statistics Abstract of 1999 shows that the leading five killer diseases in Tanzania among the population aged 5 years and above were malaria (22%), clinical AIDS (17%), tuberculosis (9%), pneumonia (6.5%) and anemia (5.5%).

Malaria is endemic in almost all parts of Tanzania, but there are seasonal variations in endemicity. Malaria transmission is stable perennial to stable seasonal over 80% of the country, approximately 26% of the territory is prone to epidemics. Malaria-free pockets are found only in higher altitude areas. Just over 90 percent of Tanzania's 34.5 million people are at risk for malaria. The estimated number of malaria cases per year is 14 – 19 million and the estimated number of deaths per year due to the disease is between 100,000 – 125,000, of which about 80,000 are children under the age of five years.[1] Malaria is the major cause of under-five mortality particularly in children aged less than two years and inflicts a huge burden due to anemia, especially in pregnant women.[2] Drug resistance is a problem throughout Tanzania.

Tuberculosis (TB) has increased five-fold in Tanzania since 1983, mainly due to the HIV-AIDS epidemic. HIV was present in 44% of TB cases in 1994-98. The annual increase is between 5-10% and the majority of cases appear in young population groups aged 15-45 years. It is estimated that more than half of the adult population in Tanzania has already been infected with TB. Dar es Salaam contributed about 25% of the total cases notified.

Tanzania has achieved high rates of coverage of antenatal care (90%), immunization (DPT3 87%-in 2001) and vitamin A supplementation (over 90%-in 2002). Measles, which used to be a common cause of child death, has been effectively contained. Despite these impressive gains, the general health and nutritional status of the population remains poor.

Infant (99/1000) and under-five (158/1000) mortality rates are on record as getting worse due to worsening poverty and the HIV/AIDS epidemic. About one quarter of all under-five deaths occur within the first month and two-thirds within the first year after birth. Tanzania is not on track to meet the 2015 targets of reducing under-five mortality by two

1 Ministry of Health, National Malaria Control Program, Tanzania Essential Health Project Mapping Malaria Risk In Africa (MARA), September 2000

2 Ministry of Health, National Malaria Medium Term Strategic Plan, 2002, Dar-es-Salaam, Tanzania

thirds unless urgent actions are taken. The leading causes of infant and child deaths in Tanzania are preventable illnesses such as malaria, pneumonia, diarrhea, malnutrition, HIV/AIDS and complications of low-birth-weight. Eight out of ten children die at home and six of them without any contact with formal health services. There are large disparities between rural-urban, and various income quartiles with the rural poor being the most disadvantaged.

Malnutrition rates are unacceptably high among children and women. The HSSP shows that about 16 percent of Tanzanian children are born with low birth weight (below 2500 grams). Low birth weight is also a proxy indicator of maternal deprivation, thus perpetuating the inter-generational cycle of deprivation and malnutrition. The onset of malnutrition starts soon after birth, and peaks by 12-18 months of age. 44% of under-five children are stunted (implying significant chronic malnutrition) and 30% under weight. Rural- urban differentials are pronounced, the rural poor being the most disadvantaged. Malnutrition rates that were on the decline in 1980s have remained largely stagnant in the 1990s. Food insecurity, inadequacies in the frequency of feeding and micronutrient deficiencies (iron, iodine, and vitamin A), and frequent illness predispose children to high risk of malnutrition. Micronutrient malnutrition is prevalent among women, about 14% in the highlands and nearly 80% in coastal areas are anemic during pregnancy, and nearly 70% are vitamin A deficient. About 25% of maternal deaths are associated with anemia.

Nearly 9000 women in Tanzania die annually due to pregnancy related causes, (MMR=529 per 100,000 live births) and another 250,000 women become disabled due to the same causes, seriously compromising their reproductive health. About 26% of adolescent girls have their first birth by the age 19 years. (TDHS, 1999). Too early and too frequent pregnancies have additional risk to maternal illness and deaths. The proportion of women receiving antenatal care and delivering with skilled personnel varies considerably across income levels and urban/rural residence. The declining number of deliveries in the health facilities from 60% in 1984 to an estimated 36% in1999 may be considered to be a reflection of some deterioration in the quality of health care being provided.

The HIV/AIDs pandemic threatens to overwhelm meager capacities at family, community and health facility levels. It is estimated that about 2.2 million people are currently infected with the HIV virus (National HIV/AIDS Surveillance Report Number 16, 2001, MOH). All regions of the country are affected though the situation differs from region to region. The regions of Dar es Salaam, Mbeya, Mwanza, Iringa, Arusha and Shinyanga are reported to be among the most affected as per the MOH report of 2001. Young people aged 15-24 account for 60% of new HIV infections and girls aged 15-19 have a six-fold risk of infection compared with boys of the same age. Other vulnerable groups include migrant workers, truck drivers, prostitutes and street children. As adults die of AIDS, many young children are left orphaned and their survival opportunities are seriously at risk. Currently the number of orphans is estimated to be about 2,000,000. About 72,000 babies become infected annually through mother-to-child transmission of HIV (MTCT). This will have the effect of raising the under-five mortality rate by a factor of 43 percent, thus wiping out all cumulative gains in child health and nutrition to-date.

3. STATUS OF TANZANIA PUBLIC HEALTH SECTOR REFORM PROGRAM

Tanzania has been implementing a number of related sectoral reforms which include the Health Sector Reform (HSR), The Local Government Reforms (LGR) and the Civil Service Reforms. The Ministry of Health has been working in close collaboration with the President's Office; Regional Administration and Local Government (PORALG) to affect the HSR. The government's main preoccupation is to ensure the availability and access to quality health services for all Tanzanians. It is believed that this can be achieved through an effective decentralization process. The HSR is now in the final phase of the implementation process which started in 2000/2001 with 31 districts, followed by 41 districts in 2001/2002 (total number of districts is 121). Council Health Management Teams (CHMTs) have been established in all the districts and are involved in developing district plans and budgets. The MOH and PORALG are currently in the stage to establish Council Health Service Boards and Health Facility Committees. These are the tools of fiscal decentralization, and ultimately community ownership. These structures are aimed at strengthening community voice in health service provision and ownership of health facilities.

The role of the central ministry is to address issues of policy, governance, regulations, legislation, financing, monitoring and quality assurance. The implementation responsibility has been devolved from PORALG to district and regional levels. The tertiary hospitals and other related institutions at this level will be managed by executive boards. Functioning central support systems will be crucial for the effective management of services at the hospitals and district-level and below. MOH continues to facilitate the strengthening of procurement and management of pharmaceuticals and medical supplies. The Ministry also is to take leadership in standardizing equipment, devising quality assurance schemes and strengthening of the Health Management Information System, including its extension to hospitals.

In the regions, the Regional Secretariat, is supposed to play the role of (i) supporting the health delivery services through the Regional Health Management Teams (ii) assessing Council Health Plans; (iii) ensuring community participation in the management of the facility through the Health Service Boards; (iv) providing support for undertaking major rehabilitations of the district hospitals and primary health care facilities. In practice some of these roles are more theoretical than real. The RHMTs have been reduced in size and efforts are in place to increase the numbers to at least four. Currently regional staff positions include the Regional RCH Coordinators.

In theory, PORALG through the Local Government Reform Programme prepares the communities to fully participate in the planning and implementation, in order to build a sense of ownership. MOH and PORALG jointly coordinate maintenance/improvement of structures, supply of hospital equipment and other logistics. Furthermore the national level annual health reviews are jointly planned prepared and conducted by the two ministries with the participation of development partners and other stakeholders including private sector and civil society.

In tandem with the public service reform, the MOH has rationalized its work force through provision of a five-year human resource development plan and the establishment of staffing levels at all health service delivery units including health management structures. The Ministry has also put efforts into the capacity building of its staff and the improvement of the working environment but the crucial aspects of appropriate remuneration, motivation, incentives and retention of the staff have to be dealt with directly by the Civil Service Commission.

Funding options: Districts have at their disposal the following funding options for health services:

i. The block grant from central government
ii. The Basket fund from development partners (at US 50 cents per capita)
iii. Direct donor support e.g. USAID, GTZ others (does not apply to all districts)
iv. Community health financing (currently in initial stage and only applicable in few districts)
v. User fees (not significant contribution because of poverty, the very poor are exempted through community committees and all chronic illnesses are exempt including RH and CS services)

The challenges that need to be addressed ahead include the following:

- The roles and responsibilities of the RHMTs. There is ambiguity on a number of administrative and technical issues which need further elaboration.
- The Regional teams do not have authority to hire and fire staff at district level. On the other hand CHMTs have a free hand to hire the staff they require within their perceived ability to pay. There is already a feeling that the councils are hiring less qualified staff who they can afford to pay. Indeed this practice is very likely to compromise quality of care at the facility level.
- Staff allocation and distribution is not properly planned and implemented resulting in some facilities being understaffed while others are over-staffed.
- The roles and responsibilities of the Zonal Training Centers in providing training in planning, management and technical support to the districts remain unclear but the potential is high. However, only the two centers in Arusha and Iringa have adequate capacity and infrastructure to provide major support to the districts. The remaining four centers will require additional investments to make them function effectively.
- The supportive function of the Regional Secretariats has to be clarified so as to enable it to handle the increased responsibilities and the growing private sector, which they have to regulate in order to assure provision of quality health services.
- The decentralization process is a great idea but the challenge is to strengthen capacity at the implementation level. The CHMTs require strong capacity building strategies to enable them to develop their own effective strategic plans, implement and evaluate their plans. In general district planning capacity is nascent. The plans are of modest quality and could make better use of available personnel funds, vehicles and commodities
- There is very limited involvement of the voluntary sector in the development of district plans. In addition resource allocation in the districts does not take into due

consideration the volume of work and contribution of the voluntary sector. The public sector gets the lion's share of the district Basket.

- There are reports of "leakages" in the utilization of district funds.

4. **USAID 1999-2004 PROGRAM: OBSERVATIONS AND IMPLICATIONS FOR THE FUTURE**

A. PROGRAMMATIC RESULTS

The USAID health strategy for 1999-2004 has a goal of "Increasing use of FP/MCH and HIV/AIDS preventive measures. The strategic framework includes three Intermediate Results:

IR1: Policy and Legal Environment Improved
IR2: Availability of Quality Services Increased
IR3: Demand for Specific Quality Services Increased

The mission's health office has divided its program into activities that address the Public and Voluntary sectors, with Policy and Behavioral Communication Change as major cross-cutting themes. The team's review of the mission program follows this structure; but then also analyzes the program in terms of Technical Results related to Family Planning, Child Survival, Safe Motherhood and Infectious Diseases.

1. PUBLIC SECTOR

Since 1999 the three USAID/Tanzania health sector IRs have focused on the public sector with a variety of interventions or projects linked to several Ministries and organizations. These interventions or projects, as listed by USAID under the heading Public Sector Support, are reviewed on programmatic aspects in this section and on technical results in the next section. The core public sector program areas in the present strategy are identified by the mission as:

Logistics supply and provision of contraceptives
Infectious Disease Surveillance
Long Term Permanent Methods
National Surveys
National BCC
Syphilis and Malaria in Pregnancy

Focused efforts in RCH quality improvement are identified as:

Initiate a Quality Improvement and Recognition (QIRI) program
Influence the district planning process and prioritize activities
Improve quality of services at rural dispensary and health centers
Expand access to refocused antenatal care -FANC (inc. IPT/syphilis screening)
Recent work with Zonal Training Centers

These activities are carried out by a wide variety of CAs through field support funds and via grants provided directly to the MOH's Reproductive and Child Health Section (RCHS) and more recently to two Zonal Training Centers in Arusha and Iringa.

MOH Reproductive and Child Health Section-Operational Support: The Reproductive and Child Health Section (RCHS) in the MOH apparently does not have a current comprehensive work plan indicating which partner participates in funding or implementing which activity. The "Annual Workplan 2003/2004 USAID Support" is limited to only those activities that are funded by USAID and does not refer to other stakeholders' roles. RCHS has also partner-specific workplans and reporting for the other major partners - UNFPA, WHO and GTZ. The Sector Wide Approach (SWAp) in which development partners agree on coordination and harmonized procedures for a coherent and comprehensive support to the MOH as a whole, does not provide resources for this section of the MOH. While USAID and other donors may have specific planning and reporting needs, this should not prevent the formulation of coordinated and coherent RCHS plans. Hence, increasing RCHS' capacity might include support to comprehensive planning and reporting instead of fragmented planning and support. The Medium-Term Expenditure Framework (MTEF) was mentioned as being the only and very useful management tool that provides an overview of RCHS' financial resources, their origin and actual expenditure. This warrants USAID's insistence to see its funding reflected in the MTEF.

USAID direct support to RCHS has been used to finance the costs of 5 technical advisors for the section (including a quality improvement specialist, a logistics specialist and a three person financial management team, lead by a CPA) and has funded a large number of workshops and training sessions. Many of these sessions, carried out in the capital, in conjunction with regional health teams, or at ZTCs, have supported the planning and rollout of USAID-supported initiatives such as FANC and QIRI. Despite the presence of the USAID-funded financial management team in RCHS, a recent audit indicates that the present financial controls are not yet adequate.

The RCHS is beginning to adapt from its vertical program history to its new roles in the context of decentralization. Core MOH functions like regulation, setting standards, developing learning materials and job aids are carried out. Implementing, training and supervision are the new responsibilities of the district health services, supported by the ZTCs.

A USAID supported RCHS Assessment Report completed in early 2000 provided suggestions on needed management changes at RCHS which are only beginning to receive attention by the MOH and other donors. If these recommendations are put into place, major restructuring of current RCHS activities would be required in order to encourage the RCHS to function effectively in the MOH's decentralized health system.

Quality Improvement Recognition Initiative (QIRI): The title of the MOH's Second Health Sector Strategic Plan (July 2003-June 2006) is "Reforms towards delivering quality health services and client satisfaction", indicating that Quality Assurance now

features high on the policy agenda. USAID has supported the QIRI program that currently is being piloted in sixteen districts in Iringa, Arusha and Manyara regions, working through two zonal training centers.

Quality improvement is an important component of USAID support for the public sector program. Beginning two years ago, USAID has supported an integrated (child survival and reproductive health) approach to quality (called QIRI) implemented by the RCHS and Council Health Management Teams with technical assistance provided by four non-resident cooperating agencies. It involves both facility assessment and improvement, a rewards system (e.g. similar to gold circle or star programs in Egypt and Togo), and provider performance improvement through training and other means. The key approach to the QIRI has been "implementation by experimentation". QIRI focuses on improvements of selected services picked (by consensus) from the National Package for Essential Reproductive and Child Health Interventions (NPERCHI). The selected components include: antenatal care, post abortion care and family planning (including long-term and permanent methods). The rationale for this approach is that it is possible (and manageable) to influence only a few elements in the reproductive health package at one time and with the resources available. Other components in the NPERCHI include HIV/AIDS diagnosis and management, prevention of infertility, cancer and childhood illness. The QIRI effort is designed to address the following performance gaps:

- All health facilities should have basic diagnostic equipment and medicine for treating common conditions
- Infection prevention
- Standardize operating hours.
- Increased supervision.
- Increased community involvement in the health facility.

The program suffers from difficulties of coordination among four cooperating agencies, which do not have permanent office presence in Tanzania. It has been slow to materialize, is well behind schedule and probably is under-resourced for what it aspires to accomplish. It is too early to determine whether this pilot program might have impact on overall program quality or contraceptive use.

Programmatic issues of relevance are the approach of QIRI, its links to other QA initiatives in Tanzania, and its institutional setting. QIRI singles out selected reproductive and child health areas for quality improvement, and does not follow current QA approaches which look at the full range of services provided by a facility. Although QIRI aims at “sustainable quality improvements”, singling out specific products for quality improvement might not contribute to the sustainability of quality improvements gained. Another argument for a more holistic service-wide approach to QA is that singling out some services for quality improvement might go at the expense of other services. QIRI management argued that singling out selected interventions is based on the approach of “starting small” and then rolling out. Several ongoing QA "pilot" programs funded by other donors (GTZ, CIDA, Ireland Aid) do explicitly look at facility wide services, and at all aspects of QA; management, human resources and facilities.

Currently QIRI efforts for the health sector are initiated from the RCHS and are thus limited to those interventions under RCHS responsibility. The positioning of QA in RCHS might hamper future expansion towards a holistic QA approach, including other aspects of health services which are outside RCHS' responsibility. Organizational experience has shown that changing initially granted responsibility is difficult to move to other levels at a later stage.

Currently, QIRI is directed at lower level facilities (dispensaries and health centers), which are underutilized. Quality issues which arise at regional hospitals, such as complicated pediatric referrals, LTPMS, infection prevention and emergency obstetric care, also must be addressed by a national QA program.

Since QA is of prime national concern and relevant to all aspects of services, a national task force or steering committee should ideally be in place to guide all QA initiatives including QIRI. Indeed, the next step in the MOH's plan for QA is to establish a National Framework for QA and to set up program guidelines. It is not yet clear whether QA will be established as an element of HSR or as a separate program initiative. An essential background review of all ongoing QA programs has been completed. The USAID pilot's focus on Recognition is unique among the pilots, although the recognition component is not yet underway. Also the USAID pilot includes, in theory, a component of Community Involvement not included in the other pilots. The Community Involvement component, however, remains poorly defined and unimplemented.

Zonal Training Centers: Six Zonal Training Centers, located strategically around the country, have been designated by the MOH's Human Resource Development Department (HRDD) as centers for coordinating "Continuing Education" programs for health cadre. HRDD has the responsibility for development, management, supervision and monitoring of activities taking place in all health training institutions in Tanzania; but has delegated the continuing education function to the ZTCs. Many of the ZTCs are co-located at health pre-service training facilities (e.g. Clinical Officers Training Centers; Assistant Medical Officers Training Center) and therefore have multiple functions. Each training center has a unique history which has affected its present level of capacity. For example, the ZTCs in Arusha and Iringa have in recent years received significant, but episodic, donor support to carry out special courses such as WHO regional training programs. The most active centers have been successful "entrepreneurs", honing and selling their services to a variety of users.

The main Continuing Education (CE) responsibilities of these institutions include: a) assess continuing education needs for health workers/service providers; b) plan and implement CE in-service training programs and activities; c) mobilize training resources to do (b); d) disseminate up-to-date information in such areas as technology and new disease management approaches; e) develop and distribute health learning materials as leaflets, pamphlets, booklets, etc. However, in concert with the Health Sector Reform process, these centers have now been required to take a more comprehensive approach to planning, managing and implementing human resource activities in support of the

decentralized health system; and in response to the needs of district and regional health teams.

These new roles are still being defined; but the Chief Medical Officer has clearly indicated his vision for a major strengthening of the six ZTCs. He believes that the ZTCs can and should play a much expanded HSR support role, for example by providing planning and management training (and follow-up supervision) for district health teams as they struggle to carry out their newly expanded responsibilities.

Since 2000 USAID has provided technical support to two ZTCs (in Arusha and Iringa), expanding their capacity to provide training in reproductive and child health. In recent years, USAID has negotiated direct grant agreements with these two ZTCs and has, in parallel, strengthened their financial management capacity. USAID partners have successfully encouraged these ZTCs to use a Performance Improvement Approach (PIA) to increasing human resource capacity. [3]USAID also commissioned in 2001 a performance needs assessment of all six ZTCs that carefully assessed their capacity to provide support for improving RCH services.

This valuable assessment found wide variations in the capacity of the six ZTCs to carry out key functions; and the results can be used as one ingredient in determining the donor support needed to upgrade the ZTC network. USAID and other donors are likely to be asked to help develop a comprehensive support package to the ZTCs so that they can quickly provide much needed support to the district health teams. While the composition of the donor support package has not been defined, it is likely to include improvement of physical infrastructure and equipment, as well as technical and financial support.

USAID's experience with the two stronger ZTCs should be utilized, perhaps within a ZTC donor task force or working group that could help plan a comprehensive approach to ZTC strengthening, while at the same time, ZTC district support programs are immediately ramped up. The content of ZTC training needs to be expanded beyond traditional in-service technical training, to include health planning, management and cost-control by district health teams. New ZTC training methodology may also need to be considered with more on-site training (and distance learning) for district teams, along with more consistent follow-up, supervisory visits to assess/review district team performance.

Logistics Management: In the early 1990s, Tanzania developed strong vertical logistics systems for family planning and EPI. During that period, many district level personnel were trained in logistics management, and RCHS (then called the Family Planning Unit) oversaw the process. EPI has maintained a partly vertical system of cold chain management and vaccine supply, which is working well, although there have been lapses

[3] The PIA methodology considers a variety of factors, beyond appropriate skills and knowledge, that are known to influence worker performance: organizational support, clear job expectations, clear and immediate performance feedback, supportive environment and motivation. P.1 Performance Needs Assessment of Zonal Training Centre: Ministry of Heath, October, 2001.

in the procurement of some family planning drugs and commodities. Stock-outs of vaccines are under 10%.

With decentralization, contraceptives were integrated into the national drug supply system. Overall, for the public sector, this seems to be working well. In February 2003, a USAID contractor conducted the Tanzania Stock Status Survey that provided a "snap-shot" of commodity availability throughout the country. Contraceptives faired reasonably well (7% to 13% stock-outs), although contraceptive implants were not surveyed, and they are reportedly scarce in both government and NGO clinics.

Other products faired less well, for example, ORS (20 % stock-out rate), eight STI drugs (14% to 44% stock-out rates) and four HIV and Syphilis Test kits (5% to 26% stock-out rates). The general weakness of logistics systems is of considerable concern, especially since it will also soon be responsible for expensive and (probably highly valued on the black market) ARVs. Forecasting capacity is not strong, and the MOH currently relies on outside technical assistance in some areas of planning and forecasting. Finally, particularly in the case of contraceptive implants, non-governmental service providers complain bitterly about non-accessibility of supplies through districts. Some type of separate distribution for FBOs and NGOs is probably required.

Data for Decision-Making: USAID has supported, and continues to support, an impressive array of short-term studies, technical assistance and major national surveys in the health sector (e.g. DHS, Tanzania HIV-AIDS Indicator Survey). A new DHS is scheduled for 2004. USAID also supports a wide range of meetings and planning processes leading to guidelines and program or policy strategies. USAID relies on national and subcontractor data for its own reporting and has a detailed Performance Monitoring Plan. Information gathering in the public sector has much room for improvement and is likely to remain an important priority for the ten year strategy, as will targeted technical assistance. Both are clearly within the USAID comparative advantage. It is relatively simple for USAID to leverage other donor support for studies such as the DHS.

The Health Management Information System (HMIS) is currently weak and does not contribute much to data for decision making, despite lengthy and substantial investment by DANIDA and other donors. The main constraints are that the current HMIS does not serve the management needs of district managers in particular. Several recommendations have been made in recent years, but most of these have not or only partially been addressed. Simplification and limiting the number of indicators which should reduce the administrative burden of district and health facility managers are expected to improve the reliability and appropriateness of data.

What is less evident at first glance is how all of this fits together to build capacity in government and the private sector to use information for pro-active program decision-making. Data clearly is used at the central level (e.g. long term method planning) and locally (e.g. to track FP users and calculate CPR), but an overall impression of the assessment team is that this is not an area of strength.

Integrated Disease Surveillance: USAID's support to infectious disease surveillance started in 1999 by contracting the Environmental Health Project/CDC to make an assessment of existing infectious diseases surveillance systems in the country. The assessment found five infectious disease surveillance systems that included TB/leprosy, HIV/AIDS, Infectious Disease Week Ending (IDWE), acute flaccid paralysis and the Health Management Information System (HMIS). On the basis of this assessment a project was designed to set up an integrated disease surveillance system based in the MOH's formulated Integrated Disease Surveillance and Response strategy, under the Epidemiology and Disease Control Section of the Director of Preventive Services. An Action Plan was developed which contains twenty-one objectives ranging from surveillance, reporting mechanisms, to laboratory capacity for disease confirmation. The Integrated Disease Surveillance project focuses on thirteen priority diseases (as defined in the national strategy), in the categories of epidemic prone diseases, diseases which are targeted for elimination or eradication and disease of public health importance. The purpose of IDSR is to provide health managers with information and with capacity to act on this information, "data for action". The project is implemented by the National Institute for Medical Research (NIMR) with short term technical assistance from several CAs. Based on the agreement with the MOH, USAID will support the piloting of IDSR in twelve Districts in Tanzania, after which it will be rolled out nationwide. Capacity for health managers to act on newly obtained information will be developed through training provided by the ZTCs.

2. VOLUNTARY SECTOR

Encouraging public-private partnerships, particularly at district level, is a key element in the Government of Tanzania program of decentralization and the Ministry of Health sector reform. USAID embraced this challenge, which is consistent with its historical comparative advantage working in the NGO and commercial private sectors and with USAID Mission strategic objectives in democracy and governance.

The Core Program Areas of the mission's Voluntary Sector program [4] are identified as:

- Voluntary Sector Health Program (VHSP)
- Social Marketing for HIV and FP
- HIV Voluntary Counseling and Testing
- Zanzibar HIV-AIDS Program

The effort has faced many challenges given the low level of NGO development and empowerment in the country and the slow pace of commercial sector development following the socialist period. Another stumbling block was a longstanding climate of "suspicion and mistrust" reported by informants to exist between the public and private sectors. Although mistrust is said to persist, the team noted a number of examples of

[4] Earlier in the strategy period, family planning support to private entities such as Marie Stopes and UMATI, would have been included in this list. Neither organization has agreed to the stipulations of the Mexico City clause; so USAID support has been discontinued.

sound public private partnership during site visits. In particular, there is a long history of collaboration between faith-based organizations (FBOs) and the government. Some FBOs have been operating Tanzania since colonial times, and most enjoy the confidence and respect of government and other private sector organizations.

USAID was able to build upon existing relationships with government to move forward an ambitious agenda in the voluntary health sector. Because the term "NGO" has a special legal meanings in Tanzania, USAID chose the term "Voluntary Sector" as generic for a variety of activities not directly managed by government. Voluntary and public sector activities are frequently complementary or overlapping. Some NGOs, such as UMATI, organized family planning activities in public sector facilities. A variety of faith-based groups and NGOs (such as Marie Stopes) received contraceptives and vaccines, training and/or Basket funding for their programs. Most community-based organizations (CBOs) refer clients from their mobilization activities to public sector dispensaries and clinics. Finally, an important part of the public-private partnership concept is a growing collaboration and interdependence at the district and regional level.

In terms of output and direct impact on health seeking behavior, the Social Marketing (SM) Program is clearly the star performer in the non-governmental sector. Social marketing accounts for at least half the condom distribution in Tanzania, growing numbers of CYP from sale of oral contraceptives and distribution of ITNs. Marketing of other products has been piloted, and USAID has moved to take advantage of the social marketing structure to market health behaviors, such as generic family planning methods. USAID has been highly successful in leveraging funding for social marketing. The program has generated funding from a variety of donors, allowing USAID to target its support for social marketing strategically.

Regulatory and bureaucratic barriers and conservative attitudes of some key stakeholders may have slowed social marketing. Examples include restrictions on social marketing of OC's at lower levels, targeted advertisement of condoms and lack of encouragement to market injectible contraceptives. Even given obstacles, social marketing has already demonstrated considerable success and is well positioned to do more. The social marketing program is national scale. As such it is positioned to act as a buffer in the event of public sector stock-outs, thereby improving access and availability.

In terms of impact on IR1 (use of services), the second largest "contributor" from the Voluntary Sector are the long term and permanent method (LTPM) programs. Up until last year, two national NGOs (Marie Stopes and UMATI) formed the backbone of USAID-supported LTPM provision in Tanzania, receiving USAID support since the early 1990's. Although the rate of sterilization remains steady at below 2%, the absolute number of procedures has gone up. It is reported anecdotally that considerable unmet demand exists, particularly in rural areas. Because the two organizations no longer conform to USAID funding criteria, USAID has discontinued its funding for Marie Stopes and, recently, for UMATI as well. Fortunately, much of the capacity built in these two institutions over the years remains and funding from other donors has been

forthcoming, so some of the negative impact of the pull-out has been muted. The LTPM program in both public and voluntary sectors faces many challenges (see FP section).

The centerpiece of USAID/Tanzania's work with NGOs and CBOs at the district and community level is its Voluntary Sector Health Program (VSHP). This program provides a large number of small sub-grants to local organizations, primarily for mobilization in HIV/AIDS, but also for family planning and child survival activities. The first contractor did not perform satisfactorily and had to be terminated, causing program delays. The current contractor has been functioning a relatively short time, and much of its level of effort has been devoted to getting over 334 small grants up and running, working intensively with key public sector stakeholders at the district level on the partnership aspects of the program and building capacity in small, inexperienced CBOs. Most grants focus on HIV/AIDS, with health prevention and social mobilization components. Only a small percentage of grantees provide services. The expectation is that these CBO grantees will forge close ties to service delivery providers (public or private) and that technical capacity in health education subject areas will improve, contributing more directly (and measurably) to district level impact. The cost of the program has averaged about $3 million per year, divided 20% child survival; 20% reproductive health and 60% HIV/AIDS.

Faith-based organizations, such as the church hospital and clinic networks, provide as many as 45% of rural hospital beds. FBOs currently receive donor support in a non-systematic way through a variety of mechanisms. Historically, FBOs have raised significant funding from European and European churches. FBOs have often not been transparent in letting Government and other partners know the level and source of funding, but it is believed that their church generated income has eroded over the past several years. Other funding sources include Basket funding (public sector), training opportunities with Zonal training centers and participation in the VSHP. Important subsidies in financial terms are provided in-kind through provision of contraceptives, vaccines and other materials that flow through the public sector. Faith-based organizations complain, however, that supplies of some items are undependable and that preference is given to the public sector. Despite longstanding involvement in RCH, considerable underutilized capacity remains within FBO networks.

3. POLICY

"Policy and Legal Environment Improved" is one of the three Intermediate Results in the Tanzania mission's health S. O. framework for the 1999-2004 period. Mission staff and USAID CAs have focused most of their efforts, successfully, on policy issues related to HIV/AIDS and particularly, the establishment of a new GOT HIV-AIDS strategy.

Policy outcomes during this period related to family planning, child survival and infectious diseases are less tangible, but still important. They include:

a. Support for the GOT's health sector reform process: USAID staff have been very active (and appreciated) participants in multi-donor and government fora that have periodically critically reviewed progress in the overall health reform

program. USAID does not contribute funds to the SWAp funding approach which channels most donor funding into direct support of the health reform program. However, USAID activities, like UNFPA and GTZ activities carried out "outside the Basket", have been included appropriately in the total funding plan for sector reform and in sector reform monitoring/evaluation.

b. USAID is an active member of the donor task force on reproductive and child health. USAID has been the lead donor for reviewing the government's annual HIV-AIDS program budget and expenditures while UNFPA (with USAID support) has the lead for reviewing the RCH program budget and expenditures. These reviews lead to donor suggestions for future year budgets. USAID also participates in a variety of other donor fora that jointly take up key issues with the MOH: these include the "quality of care" subgroup; and a "condom" subgroup.

c. New MOH technical policies or guidelines: USAID/T has successfully encouraged the MOH to become a continental leader in embracing new technical guidelines where appropriate. For example, with USAID support, Tanzania is one of only four African countries that formally adopted Intermittent Presumptive Treatment (IPT) using sulfurdoxine pyrinethamine (SP) as the standard protocol to protect pregnant women from malaria. USAID has also provided support for the development and approval of an "Essential Reproductive and Child Health Package" which has been completed and disseminated to the field. Also, USAID has played a lead role in standardizing the management of syphilis in pregnancy by supporting the development of essential guidelines.

d. NGO advocacy: USAID/T has played a lead role in encouraging the growth of civil society entities (NGOs and CBOs), only recently allowed to flourish in the wake of almost 30 years of socialist government. Several health and HIV/AIDS NGOs are included in a D&G-funded program that, inter alia, provides training to develop the advocacy skills of these NGOs. Also, as noted above, USAID's Voluntary Health Sector Program is unique in providing financial incentives to encourage district councils to allocate funds to support non-government health programs and in encouraging the concept of private-public partnerships.

4. BEHAVIOR CHANGE COMMUNICATION

Behavior change communication (BCC) is an important cross-cutting strategic component in the mission's current strategy. BCC has been used as a strategy to motivate individuals to adopt and communities to support safe sexual behaviors.

The main activities undertaken in behavior change communication have been in:

- Social marketing and behavior change for HIV and family planning
- National HIV/AIDS campaign initiative under TACAIDS

- National Reproductive Health BCC initiatives (Quality Improvement and Recognition Initiative)
- BCC initiatives have also featured extensively in other USAID supported programs which include (i) Voluntary Counseling and Testing, (ii) Voluntary Sector Health Program, (iii) Support to the HIV/AIDS NGO Cluster in Zanzibar.

Social Marketing for HIV and Family Planning:
The Goal has been to increase safer sexual behavior to prevent HIV transmission through correct and consistent use of male and female condoms. Specifically the objectives have been to improve condom accessibility, to promote behavior change and community norms and to improve targeting.

Sales for the *Salama* male condom have increased from 81,000 in 1993 to about 24 million in 2002. An estimated 34 million condoms will be sold in 2003. The specific target audiences have been young people and high risk adults, such as sex workers and migrant workers. Challenges remain. Per capita condom use is still low in Tanzania. In 2002, only about 40 million condoms were distributed in Tanzania through the public and private sectors. Uganda with about half the population of Tanzania distributed 90 million condoms over the same period. There is a need to specifically target rural youth, and to further diversify service outlets among high risk and vulnerable urban groups.

PSI social markets the female condom *Care*. Sales have been low but steadily increasing. The program started in 1998 and in 2000 some 84,500 condoms were sold increasing to over 200,000 in 2002. The challenge ahead will include research to identify appropriate clients and service outlets.

PSI markets the *SafePlan* oral contraceptive pill with the aim to increase access to women who might use them. The program was initiated in 2000 and sales in 2002 were recorded as 35,000 cycles sold. The sales are now in all regions and demand is said to be increasing. However, the challenges include the fact that up until recently, OCs could only legally be distributed through Part I pharmacies, while 72% of the population in Tanzania is currently believed to have no access to these pharmacies. Critically important policy change is under way to include OCs in Part II pharmacies (Duka la Dawas). Similarly, social marketing for injectable contraceptives is a viable alternative given its increasing demand and use with reported frequent stock-outs especially in high use areas.

With support from DfID PSI has partnered with local suppliers to market insecticide impregnated mosquito nets (ITN) with considerable success. The Global Fund's recent grant to Tanzania for a subsidized-ITN program via the public and the private sectors is likely to include some support to PSI efforts.

National HIV/AIDS: The "ISHI" Campaign
TACAIDS and multiple private sector organizations are key partners in ISHI with technical support provided by two CAs. The objectives focus on increasing risk perception among the youth, delaying sexual debut and promoting correct and consistent condom use for the sexually active. *ISHI* uses a variety of BCC strategies which include

extensive use of the mass media, public events and music concerts as well as community initiatives. Phase I of the program covered Dar es Salaam, Iringa and Dodoma regions and is expanding to cover an additional eleven regions. *ISHI* is a youth campaign designed and managed by youth for youth and the program has implementation structures both at national and regional levels. Among the challenges ahead are to increase the coverage of the campaigns in rural areas and to ensure effective reach of the hard to reach urban poor youth.

National RCH Behavior Change Communication

The main focus of the RCHS BCC efforts is the QIRI program currently being piloted. The goal of the initiative is demand stimulation through public recognition. Preparations for the initiative have been accomplished but activities are yet to take off on the ground. However, given the number of quality improvement initiatives that are being field-tested, implemented and evaluated in Tanzania, the current QIRI plans may need to learn from success stories from other players like the GTZ program in Tanga and DfID experiences in Mbeya.

General summary and overview of BCC – Findings

- BCC is considered a "cross cutting" strategy with materials being produced in every program. Recently there has been an explosion of BCC materials on HIV/AIDS and malaria due to increased funding but with little focus on community mobilization and client material needs. Diverse mass media used with targeted users
- Social marketing as a BCC strategy is effective; but the potential for social marketing of behaviors (e.g. generic promotion of FP, nutrition behaviors, child survival interventions) is under-utilized.
- Coordination is suboptimal. There is no functioning IEC Task Force and there are no "message guides". There is little evidence of sharing of costs and efforts in materials production, resulting in duplication of effort, competition among providers, high unit costs and low coverage.
- There are inadequate BCC materials for FP, Safe Motherhood, Nutrition and Child Survival (except malaria).
- BCC for Youth programs are dynamic, especially mass media
- Community mobilization and client held materials (e.g. child health cards, care giver guides) are under represented in BCC strategies. Mobilization of community, church leaders and others not systematic. CBD as a BCC strategy is neglected. BCC should focus on changing community norms in addition to focusing on individual health behaviors.
- Large quantities and varieties of materials are being produced but quality is variable. Many of available posters have too much text and have knowledge-based messages (versus changing behavior).
- Job aides have largely been neglected and most of existing job aids (counseling cards, posters, and guidelines) are not "user friendly".

B. Technical Results

1. Family Planning

a. Observations

USAID can be justifiably proud of its contribution to family planning in Tanzania. Beginning in the 1980's, USAID and UNFPA have been the lead donors in this area. Over the years, these two donors, with support from other donors in specific areas, have consistently and patiently supported both technical evolution (i.e. training, logistics systems, community-based distribution and LTPMs) and capacity building. Results are impressive. CPR rose from less than 2 percent in the 1980's to 6 percent in 1991-92 and 15 percent in 1999.

Very little capacity existed to deliver family planning services a decade ago. From these beginnings, a solid basic infrastructure for family planning service delivery is in place throughout the country. This includes a corps of trained personnel at all levels, a contraceptive delivery system which has a (relatively) low stock-out rate, basic IEC supports, guidelines and standards of practice, and technical materials. In its annual report for Fiscal Year 2003, USAID reported generation of 1.3 million couple years of protection, 217,362 of these through long term methods.

A multi-donor funded social marketing program accounts for a large percentage of CYPs generated. Currently, only oral contraceptives and male and female condoms are marketed. There are opportunities to market additional products (e.g. injectable contraceptives) as well as a range of family planning behaviors.

Condoms sales are an especially bright spot. Sales have skyrocketed to 24-30 million per year (distribution to regional warehouses). Social marketing of condoms is targeted toward youth and other high risk populations. Although condoms are marketing primarily for AIDS prevention, condom users automatically have "dual protection" from unwanted pregnancies. Traditional CYP calculations are undoubtedly inadequate to capture the potential social and demographic impacts over time of this increase, and new paradigms are needed. For example, high utilization rates by young people could translate into later "age of first birth" by the 2009 DHS. Over time, this would have positive impact on maternal health indicators and total fertility rates.

Social marketing and product advertising are among the few areas where significant legal and regulatory policy barriers remain in the Tanzania family planning program. Regulatory barriers exist, including prohibition on brand advertising, import taxes on donated commodities and drugs, and a largely ignored legal prohibition of selling hormonal contraceptives at lower level pharmacies.

Long term method rates remained stable in the 1990s, with 0.5 percent of women using IUDs and 1.5 percent sterilization. Approximately 6,000 contraceptive implants (currently Norplant) are distributed annually. Private sector providers complain of

difficulty accessing implants, which has affected method use during the last year. Capacity to deliver LTPMs grew through consistent USAID-funded technical support. Marie Stopes and UMATI have been the main foci of the program. USAID has discontinued funding to Marie Stopes, then recently to UMATI, because these organizations no longer meet USAID criteria for funding. The efforts of Marie Stopes will most probably continue with other donor funding despite the USAID pull-out. Marie Stopes maintains an active program, putting resources in both stationary and mobile sights. Meanwhile, USAID plans to refocus its LTPM support to the public sector (regional and district hospitals) and to faith-based hospitals.

Anecdotal accounts suggest an unmet demand for LTPMs. It is not known, however, whether current low rates (as reflected in percentage of method mix) result from lack of availability of contraceptives (contraceptive implants), poor access to facilities or providers doing tubal ligations (TLs), or other cultural factors. Little IEC or behavior change work is being done to promote LTPMs. The cost of contraceptive implants is high and currently only USAID funds this method. This is a long-term policy question, because any significant effort to promote contraceptive implants would require taking cost of implants into account. The USAID contraceptive procurement budget (US$1.5-1.8 million per year) already represents approximately 40 percent of its spending on family planning. Clearly, other contraceptive donors, or government, must be encouraged to step in.

The family planning program has been merged with child survival and other reproductive health components under the Reproductive and Child Health Section (RCHS). RCHS is still considered a “vertical” program within the Ministry of Health, although lines have blurred on this and the section is experiencing strain because of the added burden of other activities and internal staffing and leadership challenges. USAID and UNFPA have provided consistent financial and technical assistance to the RCHS, including support for specialized staff. There is no question that this support over the last decade has been a crucial factor in stability and growth of the family planning program. Despite the SWAp central and district "Basket" funding mechanisms, USAID and UNFPA continue to finance selected family planning and reproductive health activities through the RCHS and, increasingly, through zonal training centers.

In theory, USAID and UNFPA direct financial support to RCHS is designed to maintain program momentum in family planning and reproductive health. In practice, the broadened responsibilities of RCHS, staffing problems and lack of clarity on its role in decentralization present major challenges. Many informants also cited lack of vigorous leadership as a critical issue in RCHS performance.

Over the course of its evolution, USAID has discontinued direct funding to some program elements, most notably for community-based distribution of contraceptives. It appears that a considerable number of CBDs continue to operate out of some districts (for example, Iringa), despite lack of in-service training or other incentives. Reportedly CBDs and CHWs are also actual or potential source of volunteers for projects providing home-based care of HIV/AIDS patients. Community level family planning efforts have suffered

because of lack of focus on CBD. A modest amount of family planning is being promoted through the Voluntary Sector Health Program, but statistics on the actual extent of CBD of contraceptives through this program were unavailable to the team. GTZ is planning to train new CBDs in their focus districts. They plan to leverage Basket funding through an agreement to train new/replacement CBDs if district funding is used to provide in-service training and materials to existing CBDs. This could offer a cost effective and partially sustainable way of supporting the otherwise costly effort.

The impact on the family planning program of decentralization and new funding mechanisms raises questions. It is unclear, for example, whether Basket funding has maintained or prejudiced support at the district level for family planning (and child survival) programs. Some activities in reproductive health, such as training, are still being "directed" from the central level, and regional and district stakeholders do not—yet—seem to feel empowered to adjust programs. An example is that in some districts CBD programs continue at a low level, but Basket funding has not been allocated to re-train or to motivate CBDs.

Reproductive health programs also have had to make adjustments in light of the tremendous new burden placed on the health system and communities by HIV/AIDS. Considerable funding for prevention, diagnosis, care and treatment of HIV/AIDS has been forthcoming, creating serious problems with absorptive capacity at the implementation level. On the other hand, HIV/AIDS prevention programs have resulted in a surge of condom use, particularly among the highest risk populations (e.g. young people, transportation workers, etc.), and a spin-off of this should be reduction of unwanted pregnancies and STIS. The rapid uptake of HIV/AIDS prevention activities stresses logistics management systems and condom supplies. Although not the main condom donor, USAID acted rapidly to mitigate these problems.

As a result of some or all factors cited above, the family planning program has not grown appreciably over the past few years. Data suggest that contraceptive prevalence remains stagnant, and the number of CYP generated as a result of USAID interventions has gone down. Some of this downturn could be as a result of a poorly functioning HMIS that sometimes results in a lack of data. However, lack of dynamism of FP programs was perceived almost across the board in field visits. Several stakeholders commented that "family planning is out of fashion." Given the tremendous amount of investment USAID has made in family planning, and the impressive human, systems and physical infrastructure that exists in the public and private sectors, this leveling off of program achievement represents a "doable" challenge to reanimate the family planning program through targeted interventions.

b. Programmatic Implications:

In Tanzania, family planning must re-emerge from the shadows cast by the HIV/AIDS crisis and programs. It must build on well tested technologies and models and the existing public and private sector infrastructures for service delivery. Specific recommendations include:

- Promote social marketing, add injectable contraceptives and generic behaviors and aim for widest availability of product/large numbers of service delivery points. Assuming continued good results with condoms and oral contraceptives, high potential of injectible contraceptives, and potential for promotion of generic family planning (including long term methods) social marketing remains a key element for program impact. USAID should take the lead in negotiating with GOT on regulatory and policy barriers as a high priority in the short term. Social marketing is both an urban and peri-urban/rural strategy, aiming at large numbers of outlets to provide a contraceptive supply "safety net" when there are public sector stock-outs at the community level.
- Condoms need to be recognized and counted as a family planning method. Condoms automatically offer dual protection. Through DHS or other methods, USAID should document impact of large numbers of youth using condoms on Safe Motherhood and proximate determinates of fertility.
- Adopt an "access" strategy with public, NGO and social marketing programs for non-clinical methods only. Track evolution of numbers of service delivery points (SDPs) and availability of back-up services and supplies. To the extent feasible, most clients should have alternatives (choice) in where they can seek services, making their choices based on quality, cost, convenience, method or other considerations. CBD agents extend physical access to isolated areas. Competition often improves quality, especially treatment of clients, and increased availability will reduce drop-outs and help sustain impact.
- Promote LTPMs with ten year goals through faith-based organizations and via the public sector. LTPM strategy should focus on increasing the proportion of LTPMs in the method mix, especially tubal ligations. Medium term strategies should focus on high quality, high volume sites via regional (and selected district) hospitals and mission hospitals. The MOH should be encouraged to integrate non-USAID funded providers (e.g. Marie Stopes, UMATI, private) into its quality and SOTA working groups and encourage them to report results and continue community outreach and mobile services. LTPM program should include a BCC component and referrals from CBDs. USAID should leverage Basket funding for sustainable efforts in LTPMs. A separate analysis needs to be made of cost and technical issues with roll-out of contraceptive implants as a major method before USAID makes long-term decisions. Additional donors for contraceptive implants should be sought.
- Support zonal training centers and district training teams. This would be part of a larger, integrated approach at the district and regional/zonal level. The focus of in-service training should be at district or regional levels, through local training teams and with Basket funding. Zonal training centers can be the source for SOTA technology. Access to best practices in RH, training and computerized networks are priorities. "Job aides,"

service guidelines (summary form) and other provider materials should be simple and "user friendly" and reach to the lowest service delivery area.

- Consider providing very modest continuing technical support to an integrated, national approach to quality improvement, supported primarily through Basket funding and with leadership from other donors. Current efforts offer much in terms of technical excellence, but some duplication exists and it is unlikely they can be scaled up without large investments from several donors or via the Basket. Quality efforts need to focus first on areas where lack of quality compromises clients' lives, such as LTPMs, emergency obstetrics, IMCI referrals and over time take on larger programmatic issues. Quality, however, is unachievable without reduction of corruption in the health sector.
- Leverage Basket funding for CBD and community mobilization. Low cost models, particularly using public or Basket funding or cost-sharing with HIV/AIDS programs, should be exploited to reanimate CBD of contraceptives. This is a tactic to increase physical access in isolated communities, improve referrals for LTPMs and promote community participation in RH mobilization.
- Reanimate BCC for family planning through a more holistic approach that looks at community mobilization, client-held materials, social marketing of FP methods and stakeholder materials (e.g. pastors). BCC strategies are designed and modified to conform to national and regional "targets" for FP utilization and performance and information needs of clients. They are monitored by pro-active IEC Task Force to harmonize messages and identify gaps in funding and materials development.
- Reinforce logistics management and forecasting. This should be co-funded with the HIV/AIDS SO and other donors if possible. Efforts should focus on institutionalizing logistics management, forecasting and procurement capabilities, insuring low stock-out rates and improving systems that supply key data.

2. Child Survival and Nutrition

a. Observations

USAID is not a principal donor in child survival, but has, over the years, contributed at key points and in key ways to improving child survival programs. It continues to provide approximately $1.8 million per year in assistance, spread across a variety of interventions and cooperating agencies. Stakeholders from Government and other donors consider USAID to be a key technical partner in child survival.

The Government of Tanzania has achieved high rates of vaccination coverage, peaking at 87% DPT3 coverage in 2001 and stabilizing at around 81% for national EPI coverage. USAID estimated that 70% of eligible children were fully vaccinated in 2002. Vaccination coverage is uneven, however, and higher rates of vaccination coverage in

urban areas mask pockets of low vaccination, particularly among nomadic tribes and in border areas with high refugee populations. The EPI program, which now receives GAVI funding and has added Hepatitis B to the vaccination program, is one of the strongest public health programs in Tanzania. The process of surveillance leading to certification of polio eradication is well under way, and measles has been contained. USAID has contributed to the EPI program, notably in supporting national campaigns.

Micronutrient deficiencies are an important problem in Tanzania. Vitamin A distribution has recently been generalized, with important support from USAID. USAID provides Vitamin A for campaigns that take place twice a year. A pilot effort in the distribution (and possible social marketing) of micronutrient supplements is being undertaken by the Seventh-Day Adventist Health Services.

Nutrition has not, however, received a lot of attention in the USAID child survival portfolio, despite clear USAID comparative advantages in this area, plus the fact that as many as 43% of Tanzanian children under five are stunted and 31% are underweight. Malnutrition is an underlying cause of almost half of child deaths, and availability of household food and nutrition counseling are increasingly important in care and treatment of children who are HIV+ or have AIDS. DHS data suggest some areas where nutrition education or micronutrient supplementation could produce improvements. For example, only 37 percent of infants under the age of four months (1996 DHS) were exclusively breast fed. Promotion of frequent feeding and exclusive breast feeding for six months would improve infants' nutritional status and reduce incidence of diarrhea. Currently, the Tanzania Food and Nutrition Center is the lead institution in nutrition in Tanzania. Recent leadership change raises hopes for improved effectiveness. Nevertheless, key "essential nutrition actions" need to be broadly incorporated into child survival (and reproductive health) programs, not merely conferred upon a vertical program.

ORS appears to be institutionalized on a national scale program. Site visits noted OR units in large facilities and children being treated with ORS. Stock-outs of ORS salts were noted in a recent logistics review.

Malaria remains the largest killer of children in Tanzania; 22% of young child deaths are attributed to malaria. In response, Tanzania has developed one of the most active and well funded malaria prevention and treatment programs in Africa. Following international Roll Back Malaria guidelines, the program has implemented an insecticide treated bed net campaign. There are three local manufacturers of quality bed nets in Tanzania, and subsidized insecticide treatment sachets have been bundled in these net packages. Subsidized bed nets and insecticide treatment sachets are being made available through Basket funding at the facility level. A new program of focused antenatal care that includes intermittent treatment of pregnant women for malaria has been piloted and has proven popular with health personnel and clients, despite some side effects of the anti-malaria drugs. Chloroquine is no longer effective in Tanzania, and complex protocols exist for treatment of children and adults. The National Malaria Control Program has introduced algorithms on malaria treatment and created job aides to assist providers. A lot

of IEC materials, particularly posters, have been produced on malaria. USAID has partially supported IEC efforts. The program is beginning to show results.

RCHS is the Government focal point for Integrated Management of Childhood Illness (IMCI). WHO and UNICEF are the key technical partners, and funding comes from a variety of donors. IMCI was initiated in 1995 with adaptation of the algorithm for Tanzania. By 1998 it had expanded to 13 pilot districts and a five-year roll out plan was in place. As of June, 2003, 57 districts have implemented IMCI, and 12 districts have over 80% coverage. The IMCI program has successfully lobbied for Basket funding in 113 districts. IMCI has been incorporated into some pre-service training, especially medical schools, but training institutions lack sufficient tutors and IMCI trained clinical trainers. Community IMCI is at an earlier stage; a package of guidelines for community guidelines is being finalized, and RCHS is piloting a more comprehensive child health record. The IMCI program has recently joined forces with the malaria program, and they are agreed to work together.

A number of gaps still exist, in addition to the challenge of "rolling out" IMCI and Community IMCI at the district level. There is urgent need to adapt the algorithm to encompass special needs of infants and young children who are HIV+ or have AIDS. Pre-service training needs to be harmonized. The quality of care at referral points needs to be upgraded to conform to IMCI standards, and IEC efforts need to be streamlined and harmonized.

Despite Tanzania's impressive achievements in child survival, thirty years of gradual gains in mortality indicators are now stagnating and positive trends are being reversed. Possible factors in this decline include continuing high levels of malnutrition among rural children particularly, low birth weight, the effects of the HIV/AIDS epidemic, diseases caused by infections or unsanitary conditions, and lack of access to life saving essential drugs and medical treatment. Food insecurity and micronutrient deficiencies are important contributors to poor child health. Availability of safe drinking water and improved environmental sanitation are longer term challenges that will have to be faced over the next decade.

b. Programmatic Implications

USAID is clearly an important player in child survival in Tanzania. Its leadership is sought by other donors and local partners alike. Implications of this and analysis of existing activities versus future need include the following recommendations:

- USAID should continue to let other partners (WHO, UNICEF, etc.) take the financial and technical lead while carefully targeting gaps with flexible or geographically specific funding. USAID should pro-actively support child survival (and nutrition) programs by actively participating in all relevant technical, policy and donor groups. (e.g. GAVI, IMCI Coordinating Committee, RBM Task Force).

- Child survival programs need to be much more closely linked to HIV/AIDS efforts, especially caring for the health of HIV+ or AIDS children and orphans. USAID should participate in revisions of IMCI algorithms and development of training and IEC support materials. IMCI guidance should be the national standard for care of HIV+ or AIDS infants and young children. 72,000 HIV+ infants will be born in 2003 alone, and numbers are likely to rise. A national policy on breast feeding and HIV is needed, and it should be adjusted as new treatment protocols become available.
- USAID should increase its support for nutrition programs, either separately or as part of routine child survival efforts. Nutrition should be an important part of the child survival program over the next decade. An "essential nutrition actions" approach would fit well with the MOH "essential packages of services" approach and could be phased in over time. Other donors and Basket funding would probably be easy to attract for nutrition and nutrition education programs. Micronutrient supplementation is a cost-effective option, through public and private sector channels. Breast feeding and introduction of weaning foods could lead the effort.
- USAID should lead in coordination and harmonization of child survival and nutrition messages and IEC materials development. As in family planning, simpler and more "user friendly" BCC materials need to be generated, and duplication of effort should be avoided. USAID should support development of child and maternal health cards, such as RCHS/WHO are currently piloting. An IEC Task Force should be encouraged. Social marketing efforts should target key health behaviors.
- Community mobilization and district level BCC efforts should have specific, measurable child survival targets, for example improving breast feeding practices, EPI case finding increasing, use of ITNs, or referral of sick children. CBOs should track gains made in child survival in their communities.
- "Job aides" should be appropriate for the level they are directed at, and at the dispensary level should be simple, clear and unambiguous.
- USAID should track its child survival investments and results to ensure that child survival monies are used as efficiently as possible. HIV/AIDS funding should be added to child survival activities where there is clear overlapping objectives and needs.

3. Safe Motherhood and Post Abortion Care

a. Observations

Tanzania has high rates of maternal mortality, and trends are going the wrong direction. Morbidity due to conditions such as vaginal fistulae is significant. The percentage of deliveries that are assisted is declining, and not enough C-sections (as a percentage of

deliveries) are being done to save lives. The causes of high MM rates are numerous and familiar for developing countries: high risk births (especially very young mothers), induced abortions under unsafe conditions, maternal malnutrition, poor emergency obstetric care and/or evacuation of pregnant women. Increasingly, HIV/AIDS is driving up MM rates. It also appears that in Tanzania there is not sufficient "outrage" over maternal death. This represents an important gender discrimination issue.

With USAID technical and financial support, the RCHS has launched efforts to improve life saving post abortion care services. Anecdotal reports give these efforts high marks, and there are indications that fewer abortion complications are being seen in hospitals where PAC training has taken place. The unmet need nationally is said to still be high.

Almost 90 percent of pregnant women have at least one antenatal visit. Unfortunately, this has not been translated into lower MM rates. Part of this has to do with the fact that the majority of obstetric emergencies cannot be "predicted" through the best antenatal care. Also, family planning programs are not reaching enough people to prevent unwanted pregnancies (and induced abortions) and preventing the four "too's"—becoming pregnant too early, too late, too many times and too closely spaced. On the other hand, ANC is not being exploited sufficiently to provide information and care that could positively influence pregnancy outcomes. These include full tetanus coverage, counseling on danger signs and emergency evacuation planning, child spacing counseling, anemia prevention measures, micronutrients and nutrition counseling, STI testing, and other interventions. The GOT with USAID support has launched a "focused antenatal care" initiative that provides malaria treatment during pregnancy and syphilis screening and treatment. Anecdotal evidence suggests that between 40-60% of clients get tested for syphilis. For those who screen positive, between 60-85% actually get appropriate treatment. For malaria only up to 45% of clients do take SP as IPT in their second visit to prevent malaria. Despite this, the effort to manage syphilis and malaria in pregnancy is popular with clients and providers. Opportunities exist to translate this effort, plus PMTCT programs to improvements in ANC across the board. Focus on postnatal care also needs to be improved, especially in the case of HIV+ mothers and their infants.

USAID has contributed significantly to Safe Motherhood through specialized programs such as focused antenatal care (FANC includes MIP - managed malaria in pregnancy; and SIP - managed syphilis in pregnancy), PMTCI, Post Abortion Care, routine and surgical contraception, life saving skills for midwives, infection prevention and QIRI and other quality efforts. Given the issues related to HIV+ mothers and infants, and unacceptably high MM rates, a strong argument exists for continued, targeted assistance, especially in programs that work with hospitals and clinics and with district health management teams.

b. Programmatic Implications

USAID should continue to keep Safe Motherhood as a priority, even if investments cannot be large. A collaborative, sector-wide approach is required. Since the USAID

comparative advantage is in technical support, efforts need to be made to leverage Basket funding and/or other donors to pick up the bulk of the cost. Safe Motherhood can be integrated into community and district programs through education on "danger signs" during labor and delivery and creation evacuation plans in communities for obstetric emergencies. These community efforts must be present wherever obstetric care facilities are upgraded to complete the circle. USAID can also help by keeping the technical focus on Safe Motherhood and specifically by upgrading and integrating programs working with HIV+ women.

4. Infectious Diseases

a. Observations

USAID's involvement in infectious disease control has in recent years focused on malaria control, IMCI and on Integrated Disease Surveillance and Response (IDSR).

Tuberculosis: The USAID mission in Tanzania has not felt it necessary (as reflected in their OYB) to address Tuberculosis because of several reasons, but primarily because the vertically-managed National Tuberculosis and Leprosy Control Program (NTLP) is among the most well-funded and successful control programs in the country. Some AFR/SD regional funding includes limited support to community based DOTS and TB/HIV activities in Tanzania and has supported a TB & Gender study. The WHO advocated DOTS strategy has been implemented throughout the country since 1986. DOTS is being currently offered in almost all public and voluntary sector hospital and health centers and some dispensaries. The success of NTLP is mainly due to strict adherence to the DOTS strategy and very tight control of drug logistics. Despite these successes, TB control faces a number of challenges: the increased number of TB cases mainly due to HIV/AIDS epidemic, the need to decentralize DOTS services to involve more health facility and into community in order to increase access to TB services, and the need to increase awareness among general population in order to positively influence health seeking behavior.

Polio: Tanzania is in the process of reaching Certification as a polio free country but this must be done within the context of the East Africa region. The process to declare the region Polio free is long and has many components. Tanzania has had no wild polio reported since 1999 and no AFP cases positive for the polio virus have been reported. Tanzania has been invited to attend a final certification report in March next year to document the polio containment process that will be finalized in 2005. So far, a total of 8 countries reached this stage. Even after certification, surveillance is likely to continue because importation is possible.

Malaria: Rollback Malaria is a strong and well-funded program in Tanzania, with leadership provided by a large cadre of professionals in the EPI unit of the MOH. Tanzania's malaria control program is comprehensive and in line with Roll Back Malaria to which Tanzania is a signatory. Tanzania supports 4 key strategies, (1) improve malaria case management, (2) vector control through the use of ITN, (3) prevention of malaria in pregnancy and (4) epidemic preparedness and containment. A major new Global Fund

grant will enable Tanzania to establish a nationwide program of subsidized impregnated bed-nets for the population strata that cannot afford to purchase them. This program, managed by National Malaria Control program (NMCP), is designed to be implemented by District Health Teams as an additional to their present responsibilities with no operational resources added to district budgets.

USAID/Tanzania malaria activities focus on strategies 2 and 3 and include interventions in the use of ITN in pregnancy and preventive treatment in pregnancy. Other donors address prevention and treatment outside of antenatal facilities. The Mission has worked closely with the National Malaria Control Program and the Reproductive and Child Health Section on developing national IPT policies and standards and in the field on treating and preventing malaria in pregnancy.

In malaria control USAID has played a major role in the nation-wide changes in treatment protocols, primarily for Intermittent Presumptive Treatment for Pregnant Women (IPT). This involved training and development of job aids for all levels of health workers. Malaria treatment as an element of IMCI was directly addressed through support to RCHS (discussed above). The third avenue of USAID's support has been through the ongoing development of the IDS, which includes several diseases which are directly linked to CS/IMCI (under five diarrhea and pneumonia, polio/AFP) and Safe Motherhood (tetanus).

USAID has also focused on improving the quality of antenatal care services, with a special focus on treating malaria and syphilis in pregnancy in 16 districts. The MNH Program works on building the capacity of regional training centers to develop provider skills in performing antenatal care interventions and advocating the use of ITN. With Ministry of Health collaboration, training materials for IPT have been developed, and the new malarial treatment guideline advocating IPT policy introduced in 1999 is being scaled up. USAID also supports some PSI administrative costs for commercial marketing of ITNs including a system to track malaria drug supplies and prevent stock-outs.

USAID/Washington central funds support the large-scale Interdisciplinary Monitoring Project for Antimalarial Combination Therapy in Tanzania (IMPACT-Tz). This Centers for Disease Control (CDC) project examines malaria combination therapy and policy implications for first-line drug regimens. Significant impact has been made in modeling malaria resistance, market analysis for antimalarial drugs, adherence to artemisinin-based combination therapy (ACT) regimens, and the impact of introducing ACT. This intervention is carried out in Ifakara District, Morogoro region.

Integrated Disease Surveillance and Response: After more than two years of preparations IDSR has now taken off by carrying out capacity building activities to 8 district CHMTs in epidemic preparedness. Other technical results are IDS laboratory guidelines and a manual for data analysis by CHMTs. It should be noted that despite good intentions of integrating the infectious disease surveillance system, it is still at the very beginning of becoming an operational system.

b.Programmatic Implications

USAID's chosen roles in addressing malaria appear to be well chosen, especially given the strong funding and capacity of the Rollback Malaria Initiative. Tanzania's vertical Tuberculosis program is also very well funded by a variety of donors and there is no immediate need for USAID support. Similarly, there appears to be no need for USAID involvement in polio.

USAID support to the IDSR will result in providing health managers with the right information to take appropriate and timely action on infectious diseases.. IDSR is a crucial public health function to protect the population as was recently reconfirmed during the SARS epidemic. Building a nationwide functioning system is a long term exercise which requires external TA and financial support, beyond the typical project intervention duration of a few years. Long term USAID commitment is therefore recommended for this crucial component of health services.

Programmatic issues that still must be addressed include the relationship of the IDS to the various other Management Information Systems, notably the Health Management Information System (HMIS), and the relationship between IDSR capacity building and general management training for Council Health Management Teams. It is highly commendable that the development of IDSR goes hand in hand with training to act. This has been conspicuously weak in other information systems in the health sector. The IDSR is supposed to be complementary to the HMIS, but how the two systems will be linked up (as they are partly reporting on the same diseases) at the CHMT and health facility level is not yet clear. How other information systems like that of the National TB and Leprosy Program and of the Expanded Program on Immunization (notably for polio and AFP) and HIV/AIDS will be linked is not yet clear either since the concept of integration is not clearly articulated in the MOH strategy. It is expected that these issues will be sorted out during the implementation phase in the 12 pilot districts.

DISCUSSION OF 2005-2114 STRATEGIC OPTIONS

5. KEY PARAMETER AND ISSUES

A. USAID Funding Parameters for 2005-2115

($ MILLIONS)

ANNUAL	5YRS	10YRS
FAMILY PLANNING	4.0	20	40
CHILD SURVIVAL	1.8	9	18
INFECTIOUS DISEASES	1.2	6	12
SUB-TOTAL	7.0	35	70
HIV-AIDS			
TOTAL			

Family Planning: USAID/Washington's funding parameters for the Tanzania mission over the next ten years show a modest and stable level of funding for Family Planning - about $4.0 million/year. This has been roughly the FP budget level for the past four years. The average expenditures for the family planning program over these past four years have been for:

1. Contraceptives -approx. 40%
2. Long-term and permanent methods - 18%
3. Social marketing - 15%
4. Logistics Management - 2-3 %

   Sub-total: 75%
5. Government of Tanzania (RCHS and ZTCs) 5-10%
6. VHSP - 5-10%

The remaining funds have been used, often in conjunction with HIV-AIDS and CS funds, to support the QIRI program, policy work, DHS and survey activities, monitoring and evaluation, and program administrative costs.

Approximately 75% of family planning funds have been dedicated to four core programs that are very likely to continue over the next strategy period. Thus, ceteris paribus, the opportunities for new program development in family planning are modest over the next strategy period.

Child Survival: The child survival funding level for the future ($1.8) continues a gradual reduction in support - from $2.7 in FY00 to $2.4 in FY02 and $1.89 in FY03. In the past mission funds have primarily been used to support FANC, VHSP, QIRI, and the GOT. Therefore, given this report's recommendations regarding VHSP, QIRI and GOT support in the future, it would appear to be a good deal of flexibility to fund new child survival initiatives in the future.

Infectious Diseases: Over the past four years, the level of Infectious Disease funding for Tanzania has been highly erratic, moving from approx. $0.8 million in FY00 and FY01 to $1.8 million in FY02 and falling to $1.2 million in FY03. Most of this funding has been used to support the IPT, IDS and GOT support programs, with some funding for QIRI. The low I.D. funding parameter of $1.2 million per year allows only very modest leeway for program expansion beyond continuation of the present mission I.D initiatives.

B. USAID comparative advantage

Ministry of Health and donor officials have a consistent perception of USAID's comparative advantage as a donor; and this perception largely coincides with the USAID mission's self-perception. These areas of USAID comparative advantage are:

Training and Capacity Building
Partnering with NGOs/civil society and the private sector
Commodities, drugs and logistics management
SOTA Technical leadership with a quality focus
Strategic Planning with a "Results" focus
Survey, census and operational research design
Ability to target assistance "outside the Basket"

USAID is also recognized as Tanzania's major donor for family planning (along with UNFPA) and as Tanzania's first donor and a leading donor for HIV-AIDS.

C. Relationship to SWAp (Sector-Wide Approach)

Most donors to the health sector in Tanzania blend their funds into an elaborate SWAp program. The World Bank, the European Union and a host of European bilateral donors are the major donors, with World Bank support (up to 50% of the SWAp) projected through 2011. The SWAp program approach provides general (non-salary) funding through a "central Basket" that can be used for non-salary expenditures by the MOH and other nationwide health institutions; and through a "district Basket" that provides general funding to District Health Councils. The district Basket was initially allocated to districts on a per capita basis, but will now be allocated based on a "burden of disease" formula. The district Basket funds are only lightly earmarked with expenditure ceilings for basic non-salary budget categories (supplies, infrastructure, equipment, running costs, etc.) and a recommended level of 10% to be transferred to "non-government" health facilities and programs (e.g. FBOs and NGOs).

A combined government and donor working group develops annual SWAp plans in support of the MOH's Health Sector Reform (HSR) Program. This working group has conducted annual evaluations or assessments of key elements of the SWAp and of HSR. Each year's expenditures are carefully reviewed, with "lead" donors taking an active role (e.g. USAID for HIV-AIDS and UNFPA for reproductive health). In addition several smaller working groups (e.g. a reproductive and child health working group, a condom

working group) have been established, formally or informally, to discuss reform progress and problems.

The SWAp approach is being increasingly used in Tanzania to aggregate donor funding for other sectors such as transport. At the same time, with IMF encouragement, the Ministry of Finance is increasingly taking a lead role in donor-government relationships. Some donors, such as the Dutch and DFID, are gradually shifting their funding out of the health SWAp and into a larger Basket of overall "budget support" to the GOT. It remains to be seen if this change will result in reduced or increased per-capita government funding for health sector activities.

USAID's role, described as "supporting the SWAp, but programming its funds outside the Baskets", appears to be well accepted by most key MOH and donor officials. USAID staff have been very active (and well accepted) participants in the SWAp committees and working groups responsible for planning, monitoring and evaluating the SWAp program. USAID-funded programs are gradually being included in the SWAp annual planning process; although reporting by USAID and its CAs on program activities is apparently not consistent or complete.

Many donors appear to appreciate USAID's flexibility in targeting resources to non-government entities such as NGOs and FBOs. They also appreciate USAID's demonstrated ability to "fill gaps" in emergency situations when, for example, it was discovered last year that neither MOH nor the "central Basket" funds had been allocated to procure an annual supply of injectible contraceptives.

Donors also appreciate USAID's demonstrated ability to program and manage fast-moving funds, such as the establishment of a "Rapid funding mechanism" for HIV-AIDS in FY03. Several bilateral donors put some of their funds into a "USAID Basket" to stimulate NGO VCT activities because USAID had established the guidelines for the program and was willing to cover the financial management costs of the total multi-donor program.

Unless USAID/Washington regulations are modified, USAID/Tanzania has no choice but to continue programming resources "outside the Baskets". However, USAID should continue to be a major participant in SWAp planning and monitoring, and should strive to be seen as a strong, but somewhat unique, supporter of the HSR and the SWAp program. Some major objectives of USAID's collaboration with the SWAp in the future (also appropriate for USAID's "policy agenda") might include:

- Promoting allocation of Basket funding to finance the basic RCHS budget, similar to funding support provided now to other MOH departments.
- Encouraging Basket funding for all essential RCH and ID drugs and commodities, including family planning methods.
- Encouraging a "Results" approach to the allocation of SWAp funds.

- Restructuring the guidelines for "district Basket" allocations to a) provide more equitable levels of funding for FBOs and other non-government health facilities; and b) to provide performance incentives.

6. RECOMMENDED PROGRAMMATIC APPROACH

A. Program Vision

USAID/Tanzania's overarching goal for the next ten years, as stated in it's recent Concept Paper, is to "help accelerate Tanzania's progress toward sustainable development and reduced poverty and… to improve the quality of life in Tanzania". As a major contributor to this effort, USAID's health program goal is stated as "halting the deterioration in health status in Tanzania".

As described in Section 3, Tanzania's health system has several very positive features: a) the generous availability of health facilities, especially public and voluntary sector facilities, that are accessible to 80% of the population; and b) an institutionalized process of health sector reform that has the potential for major improvements in health service delivery.

USAID's program vision for the next ten years should be to ensure that these facilities, the availability of government and donor funds and other resources, and the sector reform process lead to "people-level improvements in RCH and ID health status". Key elements of this vision are:

- Support for efficient district and community-level application of health reform
- Encourage public-private partnerships and an efficient mix of public, voluntary and private sector provider services
- Foster quality in the provision of state-of-the-art RCH and ID services
- Stimulate critical citizenry, including the demand for quality RCH and ID services

B. Recommended Program Strategy

This proposed RCH and ID program strategy builds on the most recent USAID strategy (1999-2004), taking into account: a) Tanzania's development policy and priorities; b) Tanzania's health profile and the status of health sector reform; c) USAID's comparative advantages; d) the strengths and weaknesses of the ongoing USAID health activities; e) the programs of other donors and funding sources; and e) USAID's anticipated budget and management limitations.

This program strategy incorporates the technical recommendations for family planning, child survival and nutrition, maternal health and infectious diseases, summarized in Section 4B of this report.
Key changes from the present strategy are:

Public Sector:

- Greater technical and financial support for Zonal Training Centers to support district-level decentralization (innovative training for plng/mgt, supervision and in-service technical training)
- Reduced financial support for RCHS in a phased manner (replaced by Basket funding)
- Emphasis on the timely availability and use of quality data for decision making by the MOH and by district health teams.
- Completion of effective Logistics Management and ID Surveillance systems
- Finish support for QIRI pilot as soon as feasible. Provide very limited future support to an expected nationwide QA framework, with USAID TA input provided, at most, for Recognition and/or Community involvement components.
- Consider support for pre-service curricula changes to ensure SOTA RCH and ID training for new providers
- Encourage "results" orientation via guidelines for Basket funding and pilot incentive schemes

Voluntary Sector:

- Establish a new "Strengthened Health Service Partners" grant program available to FBOs and other umbrella (e.g. women, youth) organizations ($75-200,000 per grant)
- Revisit VSHP. Reduce FP and CS funding for VSHP and target it very carefully, tracking numerical targets such as CYP and immunization coverage.
- Expand and improve the social marketing program
- Encourage community mobilization and CBD programs via both the voluntary and public sectors
- Strengthen FBO/NGO advocacy skills & media reporting skills on health issues

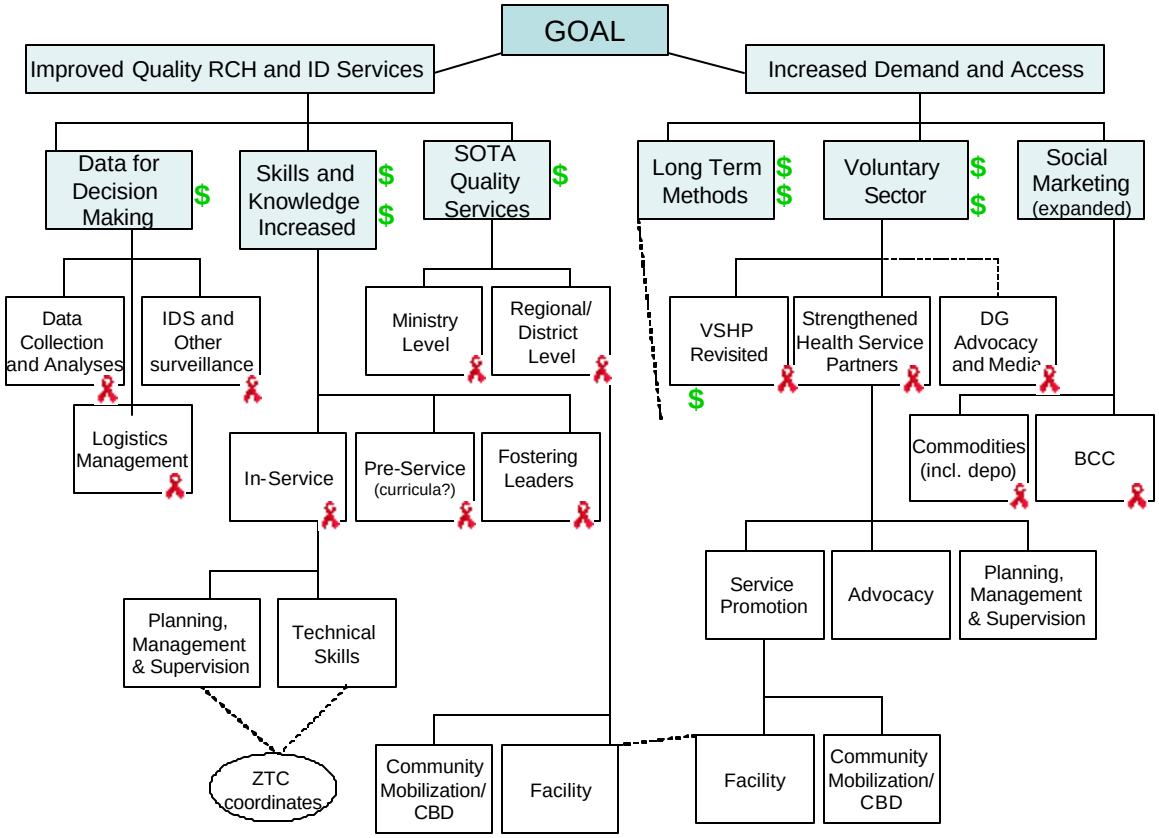
Other Activities:

- Policy activities carried out as cross-cutting issues; rather than a separate IR. Focus is on dissemination and application of existing policies.
- BCC is also cross-cutting, based on a clear "inverted" BCC strategy
- New Fostering Leadership program to encourage FP and CS champions
- More inter-sectoral activities linked with USAID DG and ENV programs

Major Changes in Technical Focus:

- New program emphasis on chronic malnutrition
- Revitalized Long-term and Permanent Method program (via both public and voluntary sectors)
- Revitalized CBD program
- Integration of Maternal health, child survival and HIV-AIDS program activities

The strategy is summarized in the Strategic Objective Framework immediately below.


GOAL
Improved Quality RCH and ID Services
Increased Demand and Access
Data for Decision Making
$
Skills and Knowledge Increased
$
$
SOTA Quality Services
$
Long Term Methods
$
$
Voluntary Sector
$
$
Social Marketing (expanded)
Data Collection and Analyses
IDS and Other surveillance
Logistics Management
Ministry Level
Regional/ District Level
In-Service
Pre-Service (curricula?)
Fostering Leaders
VSHP Revisited
$
Strengthened Health Service Partners
DG Advocacy and Media
Commodities (incl. depo)
BCC
Service Promotion
Advocacy
Planning, Management & Supervision
Planning, Management & Supervision
Technical Skills
ZTC coordinates
Community Mobilization/ CBD
Facility
Facility
Community Mobilization/ CBD

This draft SO framework which aggregates sub-programs and activities into a series of intermediate results is one method of describing the proposed USAID program, The IRs can be further defined in terms of programmatic "outcomes". The strategy team identified key outcomes for this ten-year program (below), but has not attempted to quantify these outcomes. The mission's program design process should determine appropriate outcome indicators for the first 5 years of the program and for the full 10 year strategy.

C. Illustrative Program Outcomes:

Significant Improvement in key RCH indices

- CPR, CYP and % LT&P
- Immunization coverage
- Malaria contribution to infant mortality
- Chronic malnutrition (reduced stunting)

More qualified and effective human resource cadre in targeted areas

- District and FBO human resource plans
- Quality training available and coordinated by Zonal Training Centers

National support services work efficiently and data used for decision making

- Data collection (DHS and others)
- Infectious Disease Surveillance
- Logistics management/Commodity procurement

Significantly increased public and voluntary sector RCH and ID service provision in targeted areas

- Quality RCH services available at all facilities in target regions
- Basket funding equitably distributed
- Improved efficiency in utilization of available resources (vehicles, personnel, training opportunities)
- Reduced dropout rates
- Commodity stock outs reduced
- Clinic attendance

Critical citizenry encouraged and empowered

- Revitalized community health programs & mobilized communities
- Effective non-government participation in district planning process
- Advocacy skills strengthened in key NGOs and FBOs.
- Improved media coverage of health issues and & system performance

Integration of HIV-AIDS and RCH services wherever appropriate (esp. for youth)

D. Summary of National Scope Activities and Geographic-Specific Programs

1. National Scope (Central Level) Activities

National scope activities present an opportunity for USAID to participate in achieving national goals for service delivery and systems support. The initial planning stage for Health Sector Reform in Tanzania has been largely completed and much of USAID's program focus should shift to district-level activities supported through Zonal Training Centers and Regional Health Management Teams.

However, USAID support for two key elements of MOH support services will continue to be essential for overall program success: Data for Decision Making, including continued support for DHSs and key surveys, Infectious Disease Surveillance and Logistics Management; and b) SOTA Technical Support for the MOH.

USAID has a strong comparative advantage in supporting certain programs that are most efficiently managed on a national level, rather than regional or district levels. USAID should continue to support a nationwide Social Marketing Program and a nationwide Long-Term and Permanent Methods Program, both of which are essential to achieve broad reproductive health objectives.

Finally, USAID should supplement these programs with a small, but carefully targeted Leadership Development and Support activity. This program would provide degree or specialized training and other essential support for a new generation of family planning and child survival "champions" wherever they might be located in Tanzania.

- DATA FOR DECISION-MAKING: This program objective would have three specific components: DHS and basic surveys, IDS surveillance and Logistics Management, all of which are areas of USAID comparative advantage and which USAID should continue to support.

  DHS and Surveys: A variety of activities similar to those now being undertaken should be undertaken, but with enhanced coordination and with an overarching objective of improving data for decision making. One important goal would be to strengthen numerical objective setting at the district level. Another would be strengthening routine data collection and analysis, especially in priority districts or regions. DHS surveys in 2004, 2009 and 2015 will provide overall data on health sector evolution. USAID should invest in dissemination of results, particularly in conjunction with local planning efforts. The same applies to other surveys and special studies.

Infectious Disease Surveillance: IDS is a crucial public health function to protect the population as was recently reconfirmed during the SARS epidemic. Building a nationwide system with the possible inclusion of TB and HIV-AIDS among priority diseases is a long term exercise which requires continued external TA and financial support into the new strategy period. Long term USAID commitment is therefore recommended for this crucial component of health services.

Logistics Management: Given huge USAID investments in contraceptives (about 40% of their FP budget) and investments in HIV/AIDS programs dependent on supplies (ARVs, other drugs), it is clear that, for at least the medium term, technical support for logistics, forecasting and resource planning will need to be included in the health and HIV/AIDS portfolios, hopefully co-funded with other donors.

SOTA TECHNICAL SUPPORT AND LIMITED FUNDING FOR MOH UNITS

Even though much of the "action" is now shifting to district-level program implementation, it would not be wise for USAID to abandon support to its primary MOH intermediary, the Reproductive and Child Health Section (RCHS). A major USAID objective should be to shift financial responsibility for RCHS operations from USAID and UNFPA funding to Basket funding, institutionalizing the RCHS into the central Basket program. Nevertheless, some modest levels of USAID-funded short-term technical support to RCHS, and perhaps to EPI and other MOH units, will be essential.

LONG-TERM METHODS PROGRAM

Promote LTPMs with ten year goals through faith-based organizations and via the public sector. LTPM strategy should focus on increasing the proportion of LTPMs in the method mix, especially tubal ligations. Medium term strategies should focus on high quality, high volume sites via regional (and selected district) hospitals and mission hospitals. The MOH should be encouraged to integrate non-USAID funded providers (e.g. Marie Stopes, UMATI, private) into its quality and SOTA working groups and encourage them to report results and continue community outreach and mobile services. LTPM program should include a BCC component and referrals from CBDs. USAID should leverage Basket funding for sustainable efforts in LTPMs. A separate analysis needs to be made of cost and technical issues with roll-out of Contraceptive implants as a major method before USAID makes long-term decisions. Complementary Contraceptive implants donors should be sought.

SOCIAL MARKETING

Social marketing accounts for growing numbers of CYP from sale of male and female condoms and oral contraceptives. However, the potential markets for these commodities are far from saturated. Marketing of other products has been piloted,

and USAID should both encourage inclusion of injectable contraceptives in the program, and take advantage of the social marketing structure to market health behaviors, such as generic family planning methods. The past success of USAID and the implementing CA in leveraging other donor funding for social marketing is even more essential for the future ten-years with overall demand sure to increase both via population growth and with expanded demand within the growing population.

LEADERSHIP TRAINING AND SUPPORT: This modest effort would build on USAID's small MPh degree training program and would explicitly attempt to identify, stimulate and support new or existing "champions" of family planning and child survival. The program might also finance attendance at short-term leadership courses, tailor practical training courses to the needs of groups of Tanzanian leaders and ensure periodic contact with key international leaders.

PRE-SERVICE CURRICULA REVISIONS (if included in program):
USAID, other donors and RCHS should develop a prioritized list of needs and targets of opportunity for curriculum revision, upgrading tutors skills and development of job aides in the area of pre-service training. These activities could be linked to geographic-specific inputs in priority regions. Strong "investment" by the leadership of medical schools and paraprofessional training institutions is a pre-condition for improving pre-service training. The introduction of skills-based training and some sort of certification process could be included.

2. Geographic-specific activities:

The ongoing decentralization of the health sector reform responsibilities in Tanzania leads USAID to focus more of its resources in this strategy to geographic-specific activities in focus regions and districts. Selection of focus regions or districts should be made by USAID in consultation with the Ministry of Health based on a number of transparent criteria. Ideally these considerations would include USAID program experience, co-location of activities of other SOs (especially HIV/AIDS), need and socio-economic considerations, ethnic and geographic balance, capacity of zonal training centers, strength of the CBO/NGO sector, and leadership considerations such as "readiness" to undertake changes, openness to public-private partnerships and high level leadership support (i.e. "champions") for RH and CS. However, in practical terms given the MOH's current position, USAID is likely to be asked to provide much of its field-level support to and through two of the six Zonal Training Centers. Each ZTC will have responsibility for two regions of the country. The USAID mission may wish to carryout its RCH program in the same high-prevalence regions as its HIV-AIDS program, but some of these areas already have a heavy donor presence.

Geographic-specific activities contribute, albeit modestly, to CYP and national indicators of CS, and to numerical objectives in the IRs. More significantly, these activities are a key source of results in developing long term capacity, critical citizenry and "people level impact". An important cross cutting theme of all geographic-specific activities should be

design and implementation in cost effective and efficient ways, with a view towards long term sustainability locally, and the ability of Tanzania to "scale up" proven interventions nationally.

Four categories of activities are particularly suited for geographic focus. They include:

STRENGTHENING IN-SERVICE TRAINING CAPACITY AT ZONAL AND DISTRICT LEVELS. There are six zonal training centers (two functioning reasonably well, both with some USAID support). The Ministry of Health would like to devolve responsibility to ZTCs for training of District Management Teams, service providers and key stakeholders in areas ranging from planning and management, use of data for decision-making, information technology, community mobilization skills, quality improvement and technical subjects (clinical updates). This would be part of a larger, integrated approach at the district and regional/zonal level. The focus of in-service training should be at district or regional levels, through local training teams and with Basket funding. Zonal training centers can be the source for SOTA technology.

The zonal training centers could also help develop and update curricula, materials and district training teams for routine monthly in-service training. Currently, a good deal of training is organized and staffed from the central level, which is costly and does not build capacity close to actual services.

STRENGTHENING ACCESS TO SOTA TECHNOLOGY AND SUPERVISION. An important component of a dynamic program, even one that is as well established as family planning or child survival, is access to the latest thinking and medical-technical developments. Access to State of the Art technology becomes even more important in rapidly evolving programs such as HIV/AIDS. Access to SOTA technology can be provided through access to a) courses; b) outside opportunities; and c) increased use of internet technology. Zonal training centers are well positioned to be repositories of this information and skills, and to interpret and pass them on to district and service delivery levels in both the public and private sector. Probably the most difficult and frustrating part of running any large scale health program is ensuring appropriate, consistent, timely and supportive supervision. Funding supervisor per diems and transportation is necessary but not sufficient to maintain quality. Basket funding is now available for supervision in most districts, and so the challenge is to develop tools and supervisor attitudes that make supervision work. Supervisors must also understand how data help them assess performance.

IMPROVING SERVICES AND COMMUNITY OUTREACH THROUGH FAITH-BASED ORGANIZATIONS AND MOBILIZATION OF COMMUNITIES AND VOLUNTARY SECTOR GROUPS. Significant underutilized capacity exists in the faith-based sector, including both their medical infrastructures (hospitals, clinics, community health worker outreach schemes) and their religious-social

structures (pastors, women's groups, youth groups, social service clubs). Religious institutions are the most stable civil society institutions in many communities. Targeted technical and financial support from USAID can have impact through FBOs. Reanimation of the formerly widely functioning networks of community volunteers (especially community-based contraceptive distributors—CBDs) provides an essential link to the communities. Capacity building and community mobilization are cross-over areas with HIV/AIDS. In April 2002, the Ministry of Health produced excellent Guidelines on Community-based Health Care in Tanzania. These guidelines provide a technical blueprint for rolling out community level mobilization and services, and provide parameters authorized by the government.

DEVELOPING DISTRICT INCENTIVE SCHEMES. The Basket funding mechanism provides, in theory, sufficient funding to roll out a dynamic RCH program. Moreover, child health, Safe Motherhood and to a lesser extent family planning, have good general support at the district level. Still, blockages continue to exist, including management capacity issues, inability or unwillingness to use funding for certain activities, low levels of funding for community and non-government efforts and lack of a results orientation in determining utilization of Basket funding. USAID can build capacity and help focus on priority interventions by developing incentive schemes to cost share with districts. For example, USAID might provide highly desired equipment or consumable supplies for LTPMs, if the Basket paid for training of providers or session doctors to do sterilization procedures. Almost any area of RCH could be strengthened this way.

The design of geographic specific activities is important to potential success. Resident technical support at the regional or zonal level is important, at least early on in a program. Close collaboration or joint funding between health and other sectors, particularly of the zonal training centers, is important to avoid overwhelming these institutions with too many projects, objectives and tasks. Finally, base line information gathering is required to determine the success of efforts and make mid-course corrections. Reasonable baseline data can probably be obtained without a large household survey.

F. Public-Voluntary partnerships.

USAID has made good strides in encouraging public-voluntary partnerships through its health programs. Capacity issues do persist, especially with small community and district-level CBOs. Still, capacity building as currently undertaken is by all accounts highly labor intensive, and considerable financial and human resources need to be invested before "outputs" in terms of public health impacts are achieved. Given the small size of the non-HIV/AIDS health budget, the present VHSP model of small grants and intensive capacity building should be carefully evaluated to determine if it is the best use of scarce health resources. If other sectors (D&T, HIV/AIDS, other community programs) could be encouraged to invest in this capacity building, strategies could be designed to rapidly and efficiently "add on" child survival interventions.

Whatever model is chosen, inputs and desired results would have to be explicitly specified, and tracked. Child survival or RH funds should not be used to build CBO/NGO capacity. In the short term, the VSHP should focus its child survival and family planning budgets carefully and provide USAID with data on results achieved.

Public-voluntary partnerships remain an important USAID/Tanzania strategy and core value. This refocusing does not mean that public-voluntary partnerships at the community level should not be abandoned, but rather made more efficient, perhaps through better utilization of what organized channels do exist, such as church women's groups, networks of former CBDs, etc. The VSHP worked very effectively with public sector to achieve support for CBOs. It demonstrated that both sectors should given attention, particularly training and advocacy of district health management teams. One clear measure of success of public-voluntary partnerships will be increases in Basket funding directed at the private sector and communities.

While small community-based CBOs offer limited potential for service delivery, partnerships with faith-based organizations are an underutilized partner. Reportedly 45% of rural hospital beds are in this sector, even though they are limited to fewer than 10% of Basket funding. Government relies on FBO hospitals and clinics to extend services to areas it cannot service. Actions to strengthen these already longstanding public-private partnerships should have priority, especially if they also leverage additional Basket funding. In addition, there may be considerable unexploited potential for FBOs to contribute to national child survival and family planning objectives through their "wider" network of churches, pastors, women's groups, youth groups and other stable infrastructures. This may involve partnerships with other parts of FBOs besides hospital and clinic networks. Churches and mosques and clinics and hospitals are longstanding partners. In this case also specific outcome targets need to be specified at the outset.

USAID can highlight the partnership aspects of its other programs, particularly those resulting from regular technical exchanges or cross-training of the public and private sectors. Social marketing, for example, builds public sector capacity while promoting a range of health behaviors. It relies on Government to set appropriate standards and guidelines. By utilizing implementing partners based in Tanzania, USAID is building local capacity that is available to all sectors. This is especially true in BCC. The concept of public-voluntary partnerships needs to be further refined to include a variety of efforts that are building a stronger Tanzanian private sector.

G. Policy Agenda

This strategy team agrees with the USAID/T policy advisor that "policy" should not be an IR-level objective for the non-HIV/AIDS component of the new program. Most observers believe that the key policy task for the future is not the establishment of new or revised policies in FP, CS or ID-related areas. The key tasks are a) dissemination of existing policies in user-friendly formats, especially to the lowest levels of the health care system; b) policy implementation; and c) concerted efforts to encourage some health care

providers to change their attitudes and behaviors towards elements of reproductive and child health.

An initial policy agenda for the new strategy should consider the following issues. In some cases, primary responsibility for the policy dialogue should lay with the USAID mission staff; in other cases it would be more appropriate to be designated as the responsibility of a USAID-funded CA. In many cases, these are best addressed in concert with other donors.

1. SWAp support of Health System Reform:
    - Encourage the SWAp donors to adopt a more "results-oriented" approach to annual HSR program planning and monitoring/evaluation. The results approach should also be encouraged at the district level.
    - Encourage greater equity in the ultimate use of donor funds via revised SWAp district Basket guidelines. At present a maximum of 10% may be allocated to voluntary sector health facilities, although approximately 45% of rural health services are provided by faith-based facilities.
    - Ensure that SWAp central Basket funds are allocated to replace USAID and UNFPA "project" financing for the recurrent costs and many of the development activities of the Reproductive and Child Health section of the MOH. USAID could work with the donors RCHS working group and especially with UNFPA and the World Bank to advocate for this change.
    - The use of district performance incentives should be researched and tested. For example, USAID/Senegal is successfully testing a matching grant program that provides incentives for district leaders to allocate greater amounts of block funding for district health programs. Other USAID missions are likely to have tested other models in countries, like Tanzania, where decentralization has recently occurred.

2. Social marketing:
    - Advocate for (or publicize) modification of government regulations that presently prohibit Part 2 pharmacies for selling oral contraceptives.
    - Advocate for greater liberalization in the advertising of social marketing products (especially hormonals).

3. Foster and promote more vocal Leadership for the "forgotten issues" of family planning and child survival:
    - Provide short-term opportunities for existing leaders, especially women leaders, to be rewarded as "champions", to have their "batteries charged" by attending selected international meetings or via 1-2 week "leadership training" programs.

- Continue to finance a modest number of scholarships each year for MPh level training for upcoming FP and CS leaders. Although more expensive, MPh training at a U.S. university provides greater exposure for young leaders and often tends to have greater long-term payoff than similar degree training at Tanzanian institutions.

4. Participate in USAID mission-wide efforts to encourage the flourishing of a "Critical Citizenry" in Tanzania

    - Strengthen the advocacy skills of FBOs and NGOs:
      The USAID health program should support training in advocacy skills via a "buy-in" to USAID/T's DG program which presently includes advocacy training as one component of a systemic NGO strengthening program. The USAID health program should support the efforts of some of the larger faith-based programs to train their own diocese and facility staff in advocacy skills.
    - Place greater emphasis on strengthening women's groups, including those that bring together women in the media, women lawyers, and female health professionals
    - Provide financing to a DG contractor/grantee to provide selected media personnel with the skills to evaluate and report on health programs and health issues. This might be part of a broader mission focus on media training as part of its Critical Citizenry program.
    - Encourage the advocacy efforts of the NGO policy forum to modify the recent "NGO law" which makes the registration and report requirements of NGOs more onerous.

H. Behavior Change & Communications Strategy

- USAID should “inverse the pyramid” on BCC; increasing focus on client materials and community mobilization, job aides, while continuing use of mass media, testimonials and promotional materials. Behavior change takes place at community and individual client level and yet current programs are weak at that level.
- All IEC materials should be skills or behavior based, NOT knowledge based and contribute to changing community norms.
- Social marketing techniques should be applied to health behaviors (and services) as well as products.
- USAID should promote IEC Task Force (s) to help coordinate efforts. Good materials should be promoted generically across the sector, not one project or NGO at a time. Credit can be shared.
- Job aides should be made more simple and “user friendly” and accessible for health personnel at all levels of health system.
- USAID should explore feasibility of developing Child and/or Mother’s health booklets/records that incorporate health monitoring with key messages.

I.. Pre-Service Training

The MOH, some FBO and private institutions recruit recently graduated health workers every year in Tanzania. Among the many health care workers, of special interest are workers within the clinical and nursing cadres. The clinical health workers include medical officers, assistant medical officers and clinical officers. In total the local institutions produce annually about 70-80 medical officers, 165 assistant medical officers and 650 clinical officers. Between 30-50 medical officers graduate from colleges outside Tanzania. An estimated total of 1,600 different nursing cadres graduate locally per annum.

Existing training curricular for all clinical health workers are very weak in family planning and other preventive aspects of reproductive health. The training coverage is superficial in content and basically of a theoretical nature. Therefore, on this basis the clinical health care graduates cannot be certified as family planning service providers upon graduation. All of them require in-service training in order to become competent family planning service providers. For the nursing staff the situation is slightly different. There are about four types of graduates within the nursing group. There are those who graduate as certificate, diploma, advanced diploma and degree holders. The certificate holders fall within two categories; nurse B staff who are basically in curative work and public health nurse B (PHNB) who are trained in preventive interventions. Of all the nursing staff it is only the PHNB who graduate as competent FP service providers. The annual output for PHNBs is only about 220 which represents only about 14% of all nurse new graduates. The diploma nurse graduates (Nurse A) do receive adequate coverage in IMCI knowledge and skills but their training content in FP is basically in theory and is superficial. Therefore the overwhelming majority of new nurse graduates (86%) would need in-service training to be certified as FP service providers.

Recommendation: The long-term value and cost-benefit of investing in pre-service training is impossible to dispute. Although in-service training will always be needed to update skills and knowledge, the costs of "retraining" is a large continuing burden on government and donor resources. Given that pre-service is cost-effective and sustainable, it is recommended that USAID should assist the Ministry of Health to review some of its training curricular so that more health workers graduate with skills and knowledge about FP and IMCI.

Training areas that are a "must" for service providers include IMCI (11 days basic course if done as in-service), family planning (up to six weeks), sterilization techniques (two weeks for doctors), counseling (1-2 weeks) and a host of others. As a minimum all medical officers and assistant medical officers should qualify with skills in minilap under local anesthesia, contraceptive implants and IUCD insertions and removals and IMCI. All nursing staff at certificate and diploma levels should graduate with skills and knowledge in FP and IMC.

J. Programmatic linkages of CS/RH/ID with HIV/AIDS

HIV/AIDS interacts with reproductive health and child survival at virtually every level and with every aspect of the health sector--public or private; community mobilization or medical-technical, hospital-clinic, and urban-rural. In Tanzania, combating HIV/AIDS is considered a challenge that crosses all sectors. Thus, the Government of Tanzania has conferred responsibility on TACAIDS (the HIV/AIDS Secretariat) to coordinate all efforts.

The Ministry of Health, through the National AIDS Control Program (NACP), remains a key player. It is an inescapable fact that the health system will bear the greatest single burden on its personnel, budget and capacity for the epidemic. It also is becoming increasingly clear that as international strategies and funding becomes more focused on treatment and care (including ARV therapy) and medical prevention interventions (VCT, PMTCT, etc.), more and more level of effort and funding will be directed at the health service sector. Already the epidemic places enormous strains on a health infrastructure that is ill equipped to meet the needs of Tanzanians. Declining health indicators (e.g. infant mortality, nutritional status) can thus be attributed not just to increases in the effects of the epidemic on AIDS-affected persons, but probably also to declining levels and quality of services because of overburdened health systems.

As with the health system, USAID and other donor funded health programs could easily be overwhelmed by greater funding, urgency and technical complexity of the fight against HIV/AIDS. A major programmatic challenge over the next ten years in Tanzania is to see that this does not happen. One key area of consideration is the fact that while a great deal of RCH funding goes directly to districts through Basket funding or budget support, currently the bulk of HIV/AIDS funds is programmed through individual projects.

HIV/AIDS programs need to be designed in ways that reinforce gains made in other sectors. Family planning and child survival programs must take the AIDS epidemic into account. The key to managing this challenge are programs that focus on client, provider and community needs. It must be recognized—and not merely verbalized--that people's needs cannot be separated into neat sections as can international donor efforts. Quality services demand integration of prevention and care at service delivery levels. Advocacy efforts should raise demand for quality integrated services.

The existing and well developed infrastructure for family planning and child survival services in Tanzania is a good starting point for this integration. Focused ANC, for example, builds on existing ANC clinics and care models. Many former CBDs are now being retrained to provide home-based support for AIDS patients. DHS and other survey methodologies are being utilized to collect data.

Another advantage, besides infrastructure, is the fact that family planning and child survival are "bread and butter" programs. Technologies for service delivery, while not entirely static, are well developed and stable. The public health field has known for years

in general terms what works and what does not in evolving national family planning and child survival programs. If they continue to be nursed and reinforced, these stable programs can provide an invaluable anchor for the rapidly evolving HIV/AIDS programs and technology. So each area is invaluable to the other; and both require USAID attention.

An exhaustive list of specific program areas where HIV/AIDS and RH/CS/ID should be functionally linked would be lengthy. A few key examples for Tanzania include:

- Improved integrated ante-natal care (VCT, PMTCT, FANC, nutrition, improved routine ANC, TT, micronutrient supplementation, counseling).
- Essential RH services for women living with AIDS (treatment of gynecological and other common opportunistic infections and STIs, contraception, condom use, nutrition, counseling).
- Infection prevention and safe "high risk" deliveries, especially HIV+ mothers.
- Integration of HIV and AIDS into the IMCI algorithm—materials, training, referral system and national policies.
- PMTCT plus that includes provision of ARV to mothers and fathers living with AIDS program.
- Special care guidelines and packages for HIV+ babies (72,000 newborns per year), breast feeding policies and protocols.
- Integrated packages for youth (VCT, ABC, substance abuse, family planning, violence prevention, self-esteem).
- Women's empowerment through advocacy and community-based work (e.g. faith-based women's groups, girl scouts, professional associations, etc.)
- Logistics management and forecasting of drugs and commodities; tracking of routine service data and the demographic and health impact of large scale condom use (primarily by youth) on fertility and age of first pregnancy as well as on HIV status (a new paradigm). Recognition of the dual protection provided by condoms.
- Development of child, mothers and youth health records/booklets as major client held material to summarize key health messages.
- IEC/BCC Task Forces; message harmonization and message guides.
- Social Marketing of products (ARVs, condoms, micronutrients) and behaviors.
- Use of family planning community-based distributors, TBAs and other CHWs for home-based care programs and community mobilization.
- Offering TB treatment, nutrition, BCG as a package.
- Advocacy and planning on Basket funding priorities and leveraging district funding.
- Promoting data for decision-making; dissemination of DHS results to key regional level stakeholders.
- Addressing policy obstruction issues, such as brand advertising, obstructive policies or individuals; promoting leadership and visionary thinking; keeping civil society informed.

These are only a few examples. As important as the "what" to integrate is the "how," "when," and "who"? Proven programmatic tactics include: taking an "every available opportunity" approach to cross-fertilizing programs, providing more than one service to the client (or his/her family) at each clinic visit; and promoting multiple health education messages at the same time. Physical integration of child health, ANC and FP services often relieves congestion and improves quality. Simple, easy to use job aides, Ministry of Health guidance on integration and a set of clear, harmonized health education messages that are accepted across a wide range of providers on a national scale enhance integration. Integration should begin with project design and continue throughout the entire cycle to monitoring and evaluation. To maintain optimal program emphasis, evaluation criteria, and measurable indicators should include all program elements and be specific (e.g. immunization coverage versus vague promotion of child health).

In terms of program management, coordination mechanisms will have to be created to manage funding and administrative differences, particularly the mainly project based HIV/AIDS funding and the Basket RCH funding. District Management Teams, working closely with their local private and NGO partners, will have primary responsibility for coordination of on-the-ground actions and insuring synergy. If properly managed and if coordinated in an integrated, holistic way, different funding mechanisms can work to the advantage of programs by providing back-up mechanisms and flexibility.

7. PROGRAM MANAGEMENT

A. Program Modality

The breadth and complexity of the USAID health program in Tanzania has slowly expanded after it was terminated in 1988 and later re-initiated in 1992. One continuing repercussion of USAID's unilateral program termination has been reluctance from the GOT to allow a significant USAID long-term TA presence in Tanzania. These two factors combined have resulted, for the USAID health program, in an unusual program modality: 19 separate USAID CAs carrying out portions of the USAID program with no sporadic presence in Tanzania. Very few of these CAs have local offices in Tanzania Most provide STTA from their home offices in the U.S. or from regional offices in Nairobi.

This present modality is recognized as inefficient by all parties involved. Tanzanian MOH officials describe the USAID health program as uncoordinated, difficult to understand, and seemingly "supply driven" by what each of the various CAs wants to do. The CAs report a) difficulties in coordination with other CAs and with the MOH; b) lack of continuity; and c) high costs related to large number of short-term trips to Tanzania and to the use of expatriates rather than local Tanzanian staff. They also complain this program modality adds a major coordination problem to the MOH that already has its own internal coordination problems. The USAID health office is equally aware of these inefficiencies. The office has had an unusually large staff for the funding available in the early years of the current program, needed to bear the burden of funding and coordinating nineteen separate management units and monitoring the comings and goings of nineteen separate CAs.

Recognizing these inefficiencies, the MOH now appears ready to accept a more normal USAID program modality with one major bilateral USAID/T-funded contract or cooperative agreement responsible for approximately 75-80% of the total USAID FP/CS/ID program. The remaining 20-25% would be implemented through the field support mechanism by very specialized "niche" CAs whose expertise (e.g. DHS) would be difficult to duplicate by any primary CA. The strategy options team strongly recommends this new, and more common, USAID approach for the new strategy period. However, this approach must be carefully negotiated with the Ministry of Finance as well as the MOH. The main "talking point" USAID can use to urge acceptance of this new approach is that it will lead to much higher efficiency, effectiveness and timeliness in USAID's ability to support the GOT's health reform process.

Several key issues will need to be addressed as part of these negotiations:

- The USAID program and the work of the CA must be clearly viewed by the GOT as fully supportive of the MOH program for health sector reform.
- A relatively high proportion of USAID resources (more than 50%) should be seen as supporting the public sector; with more modest support for the voluntary and private sectors.

- The number of long-term expatriates requesting work permits to work in Tanzania with the CA should be small (1-2); most technical expertise could be provided by Tanzanians or other citizens living in Tanzania and hired by the CA.
- The CA should not establish a large central office presence or a large regional presence that might be viewed as a "parallel" health program to the government's program. LTTA should be embedded as much as possible in the MOH and in the zonal training centers, either as seconded technical advisors or as essential technical staff with responsibilities for working with and training Tanzanian counterparts.
- The MOH should be fully involved in the selection process of the CA.
- A model is the successful participation by the GOT in a recent procurement by the USAID DG office.

If the GOT eventually does not accept the "one major bilateral CA" approach, another modality that would improve on the present situation with 19 CAs would be for USAID to "cluster" the same 75-80% of work into the SOWs of 2-3 field support CAs. For example, a single CA might have primarily responsibility for all/most nationwide USAID activities; while another might have responsibility for most region-specific activities.

B. Procurement Options:

If a standard bilateral program modality if accepted; USAID/T still has three major options on how to gain the needed services:

- Bilateral Acquisition: prepare a RFP for contract services
- Bilateral Assistance: prepare a RFA for cooperative agreement services
- Leader with Associate contract: "Buy into" the new ACQUIRE CA; which advertises many of the RCH skills required for the new program (improvement of clinical services, strengthened in-service training capacity, improved performance of clinical providers, policy change, funding modalities to support facility-based service delivery).

C. USAID Management and Staffing requirements:

Two major shifts in USAID management responsibilities are envisaged for the next strategy period:

- A major reduction in the number of USAID management units because of a bilateral contract or cooperative agreement for the FP/CS/ID portfolio. The CA will now assume coordination and management responsibilities for 75-80% of the USAID program.
- Very significant and rapid growth in the HIV-AIDS budget and portfolio; with little or no growth in the FP/CS/ID budget and portfolio.

These two shifts should allow USAID/T to re-conceptualize the key responsibilities of its health staff and the staff structure. Staff responsibilities would move away from the funding, coordination and monitoring of 19 CAs and would focus on:

- Funding for and coordination of only 1 prime CA with 2-4 "niche" field support CAs and with the HIV-AIDS CAs.
- "Leading the orchestra": establishing overall program policy and guidance
- Policy and program interactions with the MOH, FBOs and the private sector
- Coordination with other donors in supporting health sector reform
- Reporting to USAID/W including advocating for additional funding
- Program linkages with other USAID/W offices and programs
- Program monitoring and evaluation

The skills of the USAID staff will, correspondingly, need to change somewhat; with skills needed less for day-to-day monitoring and coordination, and more for higher-level planning, senior-level interactions, contract management, and donor coordination. The present staff will almost certainly spend much more of its time on HIV-AIDS and most might be moved into a separate HIV/AIDS staff unit, if it is created.

D. Management Linkages to the mission's HIV-AIDS program:

The concept paper for USAID/Tanzania's new strategy envisages the establishment of a separate S.O. for HIV-AIDS and another S.O. for FP/CS/ID activities; each managed by separate USAID SO team leaders with staff possibly divided into two separate offices.

Making a choice among the procurement options outlined above should also take into consideration the procurement approach chosen for the mission's HIV-AIDS program. USAID/W separate funding apportionments (or "spigots") and congressional reporting responsibilities for HIV-AIDS and FP/CS/ID tend to divide program responsibilities into specific technical program tracks and have significant management implications for the USAID mission. However, the Tanzanian reality, especially at the district and community levels, is that public and FBO facility and provider services do not have these artificial "vertical" boundaries. As one regional medical officer told his USAID visitors, "USAID has specific technical areas that it will support; our people don't look at life like this". Tanzanian public and voluntary sector facilities and providers must find ways to provide all the needed health services to Tanzanian citizens.

In essence, USAID should separate the two programs only as much as is required to meet congressional and USAID/W requirements. At the bottom of health service delivery pyramid, ideally, communities, districts and regions should "see" USAID through only "one face" - one primary intermediary or, at worst, two intermediaries whose programs and activities at the ZTC, regional, district and community levels are jointly planned and are executed with close coordination with one another.

The following conceptual framework is recommended for constructing the linkages between USAID's FP/CS/ID and its HIV-AIDS programs:

FP/CS/ID	HIV-AIDS
Appropriation	Appropriation
S.O. Framework	S.O. Framework
S.O. Agreement with GOT	S.O. Agreement w/GOT
Reporting to USAID/W ----------	Reporting to USAID/W
USAID Staff responsibility----	USAID staff responsibility
Prime CA--	Prime CA
MOH--	TACAIDS
ZTCs	
Regions	
Districts	
Communities	

To the degree possible, CAs should be chosen that have multiple skills that cross-cut the artificial USAID/W SO boundaries. For example, in lieu of both CAs working on a cross-cutting theme (e.g. policy) the CA with the more significant program requirements at the field level would, in its SOW, be required in its bid to demonstrate capacity in both HIV and FP/CS/ID policy issues. In its contract or cooperative agreement, this CA would be given responsibility for all such policy interactions with the districts where the HIV and FP/CS/ID programs are co-terminus. In the "policy" example, this cross-sectoral responsibility would almost certainly be given to the HIV CA, since the HIV policy agenda is larger than the FP/CD/ID agenda.

A program activity that focused heavily on youth with a heavy and urgent emphasis o HIV/AIDS would be implemented by the HIV implementing agent, with family planning messages integrated into the overall program. An IMCI program would be implemented by the RH/CS implementing agent, with some additional HIV funds provided to direct resources at HIV+ children.

Each of the two implementing partners would report to a single CTO in the appropriate USAID/T office; but the CTO team would include representatives from one (or more) additional USAID offices.

E. Linkages with other USAID mission programs

USAID/Tanzania's Concept Paper places a growing emphasis on supporting appropriate program linkages between and among the five USAID S.O.s, and the mission's new Program Support Objective (PSO). Unfortunately, due to summer leave schedules, the FP/CS/ID strategy team was able to talk with only one of three non-health SO team leaders (Environment) and with the Program Officer. There appear to be several areas

where the future RP/CS/ID program and other SO programs could build mutually beneficial programmatic linkages into their strategies. These include:

Democracy and Governance:

- NGO advocacy training: Several women-focused and youth NGOs (including women lawyers) are among the NGOs that PACT presently supports with a broad capacity building program. The health SO might consider funding more focused advocacy training for those NGOs with an interest in promoting reproductive and child health.
- Media training: A young democracy needs a vibrant and active media to inform and to provide "watchdog" functions; but that media also needs to be better qualified to understand and report on health issues. If the DG office decides to include a media component to its program, modest health (and HIV-AIDS) funding might finance a health-specific training course for key press, radio and television reporters.
- Accountability: Tanzania is reported to be among the 3-4 "most corrupt" countries in Africa. "Leakage" from financial resources, now increasingly passes down to district governments and district councils for health activities, can significantly impact health programs. ZTC planning and management training programs for district council teams should consider including elements in the curricula that would discourage or impede the "democratization of corruption" in Tanzania.
- District Incentive schemes: In USAID/Senegal where government decentralization is also being implemented, the Health and DG offices jointly support a pilot program that established a "matching fund" incentive scheme that increases funding for districts that decide to allocate a high portion of their annual central government "block grant" to health activities. This and similar incentive models can be considered for Tanzania and could benefit from a great deal of USAID DG experience in countries with longer histories of decentralization.
- Parliamentarians supporting HIV: This ongoing DG/health supported collaboration should consider broadening its focus to reproductive and child health.

Environment:

- Improved health services in buffer zone communities: Many communities located in buffer zones around national parks and protected areas (PAs), often lose their traditional access to natural resources in these PAs. Communities in the regions supported by the USAID environment program (in the Arusha region and in coastal regions) want better health services. These buffer zone communities should receive a level of priority for USAID health programs supported from the ZTCs and for CBD programs. The health program should consider working through 1-2 primarily-environmental NGOs (such as the Masaai Advancement Association) encouraging those groups to accept a broader mandate that includes family planning and HIV-AIDS. In Madagascar, the placement of a Univ. of Michigan Pop-Environment Fellow for 2 years at such an NGO has added momentum to a similar program.

- The Jane Goodall Foundation has a growing funding base and a growing program in Tanzania. The mission should explore that foundation's interest in adding a reproductive health/HIV component to the Goodall-funded programs.
- In high risk ecoregion, USAID could explore integrating population, child survival and environmental protection "champion community" programs along the lines of programs piloted in Madagascar.

Program Support Objective (PSO): Proposed PSO-funded and coordinated activities can be important additions to the mission health program. They include a) much needed improvement in ICT skills for USAID partners; b) participant training- ideally broadened to include a variety of "leadership" development concepts; and c) Global Development Alliance opportunities to foster private sector support for development activities.

Similar to our discussion above regarding the structure of USAID health and HIV-AIDS collaboration, funding would normally be transferred from one S.O. to another based on which office logically would have the "lead" or comparative advantage for implementing the desired program (e.g. advocacy activities via DG; PSO monies for district ADP via health).

8. KEY QUESTIONS YET TO BE ANSWERED: ASSUMPTIONS, FEASIBILITY AND DATA ISSUES

Assumptions: These assumptions need to be verified as much as possible prior to finalization of the strategy

- Central Basket funding for RCHS will be available to substitute for USAID support
- The role of the Zonal Training Centers will be officially broadened to encompass greater support responsibilities for district-level health sector reform (e.g. coordination of HRS training for their zones)
- The Regional Health Teams will continue to include a Reproductive and Child Health specialist
- The size of the District Basket is adequate. The more significant problem is the effective allocation and use of these resources (e.g. planning, management, supervision).
- Other donors will take the lead on implementing a national Quality Assurance program, if it is instituted by the MOH
- Internal Champions exist in the medical and nursing schools who will provide leadership in revisions of pre-service curricula revisions
- DHS results will be available soon to verify assumptions in this report, to develop targeted strategic outcomes (5 and 10 year) and to provide health strategy baseline data. May need to supplement with rapid cluster survey in potential USAID focus regions

Key Feasibility/Design Issues:

Breadth and scope of USAID support to Zonal Training Centers: Which (and how many) ZTCs will MOH ask USAID to support? How best to structure USAID assistance to the selected ZTCs. Availability of donor partners to work with ZTCs (especially World Bank funds for intrastructure and equipment). Feasibility of "pairing" weaker ZTCs with stronger ones.

How best to provide District-level Incentive Funds and incentive programs (review USAID and other donor models from other countries, not limited to health sector incentives).

Potential demand for injectible contraceptives and feasibility study for social marketing of injectible contraceptives. A study being undertaken

now will provide additional information on this important area, and PSI should be encouraged to develop a feasibility study (if not already existing) on social marketing of injectible contraceptives.

Estimate of contraceptive requirements ten years out using different assumptions of population growth and method mix. Cost of methods given different assumptions; gap in funding sources. Special attention should be paid to the impact of contraceptive implants program expansion on cost of contraceptive procurement.

Behavior Change and Communications Issues: The upcoming Assessment should look at the challenges widely, including: i.) community mobilization; ii) materials for clients; iii) job aides and policies; iv.) social marketing behavior change; v.) Capacity building for IEC, mass media, etc. and vi) coordination and scaling up of bcc. This could be done across HIV/AIDS and CS/RH/ID.

Elaboration of Nutrition and micronutrient program possibilities. Possibly a field visit from USAID/Washington to further spell out key targets over ten years for USAID in nutrition and micronutrient supplementation. Review of existing efforts and literature search of past efforts (e.g. Iringa Nutrition Project).

CBD Working Group (RCHS, selected CAs, Pathfinder Fund, GTZ, USAID, UNFPA) to assess the current status and numbers of CBDs operating (or with the potential to operate) in public and private sector. Elaborate on in-service training needs, IEC and other supports/motivation (e.g. T-shirts) and on requirements for new training at district levels. Research data on effectiveness and previous strengths and weaknesses, ability of effort to scale up, funding available in Basket and CBDs as referral agents for LTPMs. Study extent and effectiveness of CBD in VSHP and mid-course suggestions. Look at linkages with HIV/AIDS.

ANNEX
SOME PERSONS INTERVIEWED BY STRATEGY TEAM

USAID/Tanzania:

Health Office: John Dunlop, Office Director
Janis Timberlake, Voluntary Sector Coordinator
Elizabeth Loughren, Policy Coordinator
Michael Moshi, Public Sector Specialist
Jim Allman, Public Sector Coordinator
Patrick Swai, Infectious Diseases Specialist
Lisa Baldwin, BCC Coordinator
Vickie Chuwa, M&E Specialist

Program Office: Erin Holleran
Hedwiga Mbuya
Natural Resources Management Office: Daniel Moore
Democracy and Governance Office: Magdalena Hiza

Ministry of Health:

Dr. Gabriel Upunda, Chief Medical Officer
Dr. Ali Mzige, Director, Preventive Services
Dr. Ahmed Hingora, Health Sector Reform Secretariat
Dr. Catherine Sanga, RCHS Coordinator
Dr. Z. Berege,
Dr. Tarino, President's Office, Local Government (did someone meet with him?)
Angelina Ballart, QI advisor, RCHS
Rollback Malaria coordinator, EPI

NIMRI: selected representatives

Donor Organizations:

Dr. Emmanuel Malagalila, World Bank
Ms. Cordula Schuemer, GTZ
Dr. Kigadia, UNICEF
Mr. Tom Merrick, World Bank/Washington
Dia Timmermans, First Secretary, Royal Netherlands Embassy
Mr. Thor Oftedal, Deputy Representative, UNFPA

Cooperating Agencies:

Ms. Grace Lusiola, EngenderHealth
Mr. Barry Chovitz, JSI, Logistics Management Splst.
Mr. Brad Lucas, PSI
Mr. Rockwell Griffen, PSI
Mr. Shawn Mayberry, PSI
Mr. Michael O'Leary, JH CCP
Ms. Stephanie Posner, Abt/PHR+

Mr. Charles Pill, Policy project
Mr. Ian Tweedie, JHU
Ms. Carolyn Baer, JSI/Deliver
Ms. Elaine Roma, Jhpiego
Ms. JK Vukner, Intrah
Ms. Peggy Chibuye, Intrah/Prime
Ms. Ester Brough, JHU CCP
Ms. Ann Wei, Measure
` Mr. Larry Casavva, Core Group
Dr. Calista Simbakalia, Director, Healthscope
Dr. Binagwa Fulgence, CARE
Mr. Dan Craun-Selka, PACT
Dr. Nelson Keyonzo, former Pathfinder/Tanzania director
Mr. Paul Fishstein, MSH

USAID/W:

Ms. Willa Pressman, Tanzania coordinator
Ms. Dana Vogel, Office of Population
Dr. Al Bartlett, Child Survival Splst
Mr. Scott Radloff, Office of Population
Mr. Mark Austin, Office of Field Support
Ms. Mary Harvey, Africa Bureau
Ms. Norma Wilson, monitoring and evaluation
Ms. Mary Etling, Malaria Specialist

Arusha Region Visit:

Dr. N Ole King'ori, Regional Medical Officer
Ms. Lillian Regional RCH Coordinator
Dr. S.S. Ndeki, Principal, CEDHA (Zonal Training Center)
Dr. Jincen, CEDHA
Dr. Hugo, Marie Stopes
Mr. Emilian Orasa, Acting District Medical Officer, Manduli
Dr. Danka, Clinical Officer, Mtwombi Health Center
Dr. Goka, Assistance Clinical Officer, Mtwombi
Dr. Peter Kapene, Medical Director, Lutheran Church of Tanzania
Mr. Malakai, Financial and Administrative Officer, Lutheran Church of Tanzania
Richard Mkaturgo, PHC Coordinator, LCT
Mr. Mehomne, Regional Government….
Dr. Shayo, …..urban clinic
Chief Matron, Arusha